1

14644

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14642

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Paul	Middle MARTIN	Last SACHS
2a. DATE OF DEATH Month	October	Day 16	Year 1969
2b. HOUR	3:15 PM		
3. SEX	MALE		
4. RACE	WHITE		
5. DATE OF BIRTH	10-2-44		
6. AGE (In years last birthday)	25 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN
7a. BIRTHPLACE (State or foreign country)	WASHINGTON D.C.		
7b. CITIZEN OF WHAT COUNTRY?	AMERICAN		
8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐			
9. COUNTY OF DEATH	MONTGOMERY Md.		
10. CITY OR TOWN OF DEATH	TAKOMA PARK		
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	WASHINGTON SAN. & HOSPITAL		
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	none		
12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	MARYLAND		
13b. COUNTY	PRINCE GEO.		
13c. CITY OR TOWN	TAKOMA PARK		
13d. INSIDE CITY LIMITS? YES ☒ NO ☐			
13e. STREET AND NUMBER	7204 15th AVE.		
14. FATHER'S NAME First	MAX	Middle	Last SACHS
15. MOTHER'S MAIDEN NAME First	FLORENCE	Middle	Last SHAPIRO
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	NO		
16b. SOCIAL SECURITY NO.	NONE		
17. INFORMANT	CHART	Address	Washington San. & Hospital

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Spastic
DUE TO, OR AS A CONSEQUENCE OF (b) Progressive Malnutrition + Dehydration
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 269.9
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	None	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES ☐ NO ☒		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town / County / State

22a. **I certify** that (I) (this hospital) attended the deceased from 1945, 19___, to 10/16, 1969, that (I) (we) last saw the deceased alive on 10/16 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) ~~(did not)~~ view the body after death.

22b. SIGNATURE	M.A. Diamond Md	DEGREE ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED 10/16/69
22d. PHYSICIAN'S NAME (Type)	Herbert H. Diamond	22e. ADDRESS	911 Silver Spring Ave. Silver Sp. Md

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County) (State)
BURIAL	Oct. 17, 1969	Mount Lebanon Cemetery	Hyattsville,	Maryland

24. FUNERAL DIRECTOR	Donald M. Stein	ADDRESS 232 Carroll St., N.W. Wash., D.C.	25a. REC'D BY REGISTRAR DATE OCT 21 1969	25b. REGISTRAR'S SIGNATURE J Charles Judge
	Hebrew Memorial Funeral Home			

VR A15 rev 4SM - 7-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14645 14643

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print): First FRED Middle M. Last SADLER
2a. DATE OF DEATH: Month 10 Day 2 Year 69
2b. HOUR: M
3. SEX: MALE
4. RACE: White
5. DATE OF BIRTH: 3/28/92
6. AGE (In years last birthday): 77 YRS. IF UNDER 1 YEAR: MONTHS 6 DAYS 4 IF UNDER 24 HRS.: HOURS MIN
7a. BIRTHPLACE (State or foreign country): VIRGINIA
7b. CITIZEN OF WHAT COUNTRY? U.S.A.
8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
9. COUNTY OF DEATH: MONTGOMERY Md.
10. CITY OR TOWN OF DEATH: SILVER SPRING
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): HOLY CROSS
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Farmer
12b. KIND OF BUSINESS OR INDUSTRY: Retired
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland
13b. COUNTY: MONTGOMERY
13c. CITY OR TOWN: ROCKVILLE
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 30 W. Middle Lane
14. FATHER'S NAME First Middle Last: William Sadler
15. MOTHER'S MAIDEN NAME First Middle Last: Louisa Gilbert
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: 230-24-8516
17. INFORMANT Address: Mrs. Mary Collins-sister-same #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) C.V.A.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4369
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Renal Effluvium (R) Lung + Chronic Lung Disease

19a. DATE OF OPERATION: 9-28-69
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Fractured (R) Hip
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month 9 Day 27 Year 1969
21c. HOW INJURY occurred (Enter nature of injury in Part 1 or Part 2, Item 18.): Fall @ Nursing Home
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.): MANOR CARE Md.
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 9-27-69, 19___, to 10-3-69, 19___, that (I) (we) last saw the deceased alive on 10-3-69 19___, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

22b. SIGNATURE: Lorenzo Marcolina MD DEGREE ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 10-3-69
22d. PHYSICIAN'S NAME (Type): Lorenzo MARCOLINA MD
22e. ADDRESS: 9801 Georgia Ave

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 10/5/69
23c. NAME OF CEMETERY OR CREMATORY: Marshall Family Cemetery
23d. LOCATION (City or Town) (County) (State): Bristol, Virginia

24. FUNERAL DIRECTOR: Tyson Wheeler Funeral Home
ADDRESS: 1331 Rock Pike Rockville, Md.
25a. REC'D BY REGISTRAR DATE: OCT 6 1969
25b. REGISTRAR'S SIGNATURE: Charles Lee

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

1

14646

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14644

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Clara	Louise	Safford	October 25 1969	3:30 a M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
Female	White	July 23, 1871	98 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
District of Columbia	U.S.A.	NEVER MARRIED [X]	Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Takoma Park	Washington San. & Hosp.	Teacher	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
D. C.	Washington	D.C.	YES [X] NO [ ]	3601 Conn. Ave. Apt 402

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Hiram Sprague		Safford	Elizabeth		McPeake

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
No		Hospital Records

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Ventricular fibrillation — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 427.0

DUE TO, OR AS A CONSEQUENCE OF (b) Hyperkalemia & Uremia — 4 days

DUE TO, OR AS A CONSEQUENCE OF (c) Congestive Heart Failure — 3 yrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Pneumonia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work / Not while at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that (I) ~~(this hospital)~~ attended the deceased from June, 1969, to Oct 25, 1969, that (I) ~~(we)~~ last saw the deceased alive on Oct 24 1969, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ (did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS. / MED. DIRECTOR / STAFF PHYS.	22c. DATE SIGNED
R. H. Sandstrom	MD	ATTENDING PHYS. [✓]	10/25/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
R.H. Sandstrom	7701 Carroll Ave Takoma Park, Md

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Cremation	10/27/69	Lees Crematory	Washington D. C.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
J. Wm. Lees Sons, Co. Washington. D. C. 500 4th St. NE	OCT 29 1969	J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

4

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

68
16
2
2
1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14647 14645

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last: William, A Sargent SR
2a. DATE OF DEATH Month Day Year: 10 4 69
2b. HOUR: 9A M
3. SEX: M
4. RACE: W
5. DATE OF BIRTH: 5/28/89
6. AGE (In years last birthday): 80 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN
7a. BIRTHPLACE (State or foreign country): N.Y.
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
9. COUNTY OF DEATH: Montgomery Md.
10. CITY OR TOWN OF DEATH: Silver Spring
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Holy Cross Hosp.
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired Mechanic
12b. KIND OF BUSINESS OR INDUSTRY: Air Co
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md
13b. COUNTY: Pro Geo
13c. CITY OR TOWN: College Park
13d. INSIDE CITY LIMITS? YES ☐ NO ☐
13e. STREET AND NUMBER: 9401 Rhode Island Ave
14. FATHER'S NAME First Middle Last: Eugene Sargent
15. MOTHER'S MAIDEN NAME First Middle Last: Bertha Georgia
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: 082 168359
17. INFORMANT Address: Francis Sargent College Park Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Sepsis Coma + Renal Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 DAYS
1890
DUE TO, OR AS A CONSEQUENCE OF (b): Gastric Carcinoma — 5-6 Mos
DUE TO, OR AS A CONSEQUENCE OF (c): Adenocarcinoma of left Kidney — 6 Mos
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Arteriosclerosis
19a. DATE OF OPERATION: —
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, EARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from April, 1957, to Oct 4, 1969, that (I) ~~(we)~~ last saw the deceased alive on Oct 4th 1969 and that in (my) ~~(our)~~ apinian death occurred on the date and hour and from the causes stated above, (I) ~~(we) (did) (did not)~~ view the body after death.

22b. SIGNATURE: [signature] DEGREE ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 10-4-69
22d. PHYSICIAN'S NAME (Type): Harold Sterling MD
22e. ADDRESS: Bol University Blvd E Hyattsville Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Oct 6, 1969
23c. NAME OF CEMETERY OR CREMATORY: Ft Lincoln Cemetery
23d. LOCATION (City or Town) (County) (State): Colmar Manor, Pro Geo Md.
24. FUNERAL DIRECTOR: F. Gasch's Sons ADDRESS: Hyattsville, Md.
25a. REC'D BY REGISTRAR DATE: OCT 6 1969
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4) 45M - 1/69

1 3 Items 18, 22a

14648 18, 11/17/69, cr Item #6, Film G 18 11/4/69 km

14646

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE KNOWN OF DEATH / ESTIMATED	Month	Day	Year	2b. HOUR
Ollie	J	Saunders	☒ / ☐	Oct	15	19 69	3:00 A.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS	DAYS	IF UNDER 24 HRS.: HOURS	MIN.	2c. DATE PRONOUNCED DEAD: Month	Day	Year	2d. HOUR
female	negro	11-17-00	69 YRS.					Oct	15	19 69	3:00 A.M.

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Virginia	U S A		Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Wheaton	University Nursing Home	Domestic	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Wash D C		Washington	YES ☒ NO ☐	1229 G St S E

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Joseph		Saunders	Lidia		Patterson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no	577-24-2207	Margaret McFadden - 908 Div. Ave NE

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bilateral Lobular Pneumonitis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 486.X
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Belden R. Reap M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type) BELDEN R. REAP, M.D. ADDRESS (Street, city, town or county) [illegible]

22b. DATE SIGNED Oct. 15, 1969

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	10-21-69	HARMONY PK.	LANDOVER, MD.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
ROLLINS FUNERAL HOME, INC. 4339 HUNT PLACE, N. E.	OCT 23 1969	J. Charles Judge

VR A15ME (5) 10M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14649 14647

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Joseph	Arlington	SAVANNAH	Oct. 26 1969	1:50 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
male	white	5/11/92	77 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
Penna	USA		Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
Bethesda	Suburban Hospital	Carpenter - Retired	Building

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER
Maryland	Montgomery	Wheaton		13005 Matey Road

14. FATHER'S NAME First Middle Last	15. MOTHER'S MAIDEN NAME First Middle Last
Joseph Savannah	Pauline Donohue

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
NO	577 20 1952	William SAVANNAH - SON - add same

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	myocardial infarction	unknown
DUE TO, OR AS A CONSEQUENCE OF (b)	arteriosclerotic heart disease	
DUE TO, OR AS A CONSEQUENCE OF (c)		

410.9

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Epistaxis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that (I) (this hospital) attended the deceased from 24 Oct, 1969, to 26 Oct, 1969, that (I) (we) last saw the deceased alive on 25 Oct 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED
Paul J. Noone	M.D.				26 Oct 69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
PAUL J. NOONE	5201 Randolph Rd

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	10-29-69	Cathedral Cemetery	Scranton, Penn.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Smith Warner E. Pumphrey Inc.	8434 Georgia Ave. Silver Spring, Md.	OCT 29 1969	J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physicion.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
45M - 1/69

Medical Examiner - DR. Ball - Not filed

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14650

CERTIFICATE OF DEATH

14648

1. DECEASED-NAME (Type or print) First: Dorothea Middle: Last: Scherp
2a. DATE OF DEATH Month: 10 Day: 12 Year: 69
2b. HOUR: 12:45 AM/PM
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH: 12-22-84
6. AGE (In years last birthday): 84 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): New York
7b. CITIZEN OF WHAT COUNTRY? U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. COUNTY OF DEATH: Montgomery Md.
10. CITY OR TOWN OF DEATH: Bethesda
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sibley
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HOMEMAKER
12b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.
13b. COUNTY: Mont.
13c. CITY OR TOWN: Bethesda
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 6407 Maiden Lane
14. FATHER'S NAME First: GEORGE Middle Last: GEISEL
15. MOTHER'S MAIDEN NAME First: ELIZABETH Middle Last: WACKERBARTLE
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes give war or dates of service): ***
16b. SOCIAL SECURITY NO.: NOT AVAIL
17. INFORMANT: Son - Henry - Same Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 hours
DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic Heart Disease — Many Yrs.
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 410.9

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☒ NO ☐
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from _____, 19 65, to 10-12, 19 69, that (I) (we) last saw the deceased alive on 10-12 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: James W Egan DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 10/12/69
22d. PHYSICIAN'S NAME (Type): JAMES W. EGAN, M.D.
22e. ADDRESS: 5413 CEDAR LANE, BETHESDA, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION
23b. DATE: 10-13-69
23c. NAME OF CEMETERY OR CREMATORY: CEDAR HILL CREMATORY
23d. LOCATION (City or Town) (County) (State): SUITLAND, PR. GEO. MD.
24. FUNERAL DIRECTOR: ROBERT A. PUMPHREY, ADDRESS: 7557 WISCONSIN AVE. BETHESDA, MARYLAND.
25a. RECD BY REGISTRAR DATE: OCT 15 1969
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use os the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removol, and in ony event, within 72 hours after death.

VR A15 (4)
45M - 1/69

1B 14651

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14649

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: MARY	Middle: Mc Nulty -ANN-	Last: SCHROEDER	2a. DATE OF DEATH Month: OCT	Day: 14	Year: 1969	2b. HOUR: 1:09 M
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: 4/11/18	6. AGE (In years last birthday): 51 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN		
7a. BIRTHPLACE (State or foreign country): PENNA	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: MONTGOMERY Md.				
10. CITY OR TOWN OF DEATH: 70 Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): SUBURBAN	12a. USUAL OCCUPATION (Kind of work done during most of warking life, even if retired.): HOUSE WIFE	12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceosed lived, if institutian: Residence before admission) STATE: 15 MARYLAND	13b. COUNTY: MONTGOMERY	13c. CITY OR TOWN: Bethesda	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 9916 PARKWOOD DR			
14. FATHER'S NAME First: BERNARD	Middle	Last: McNULTY	15. MOTHER'S MAIDEN NAME First: MARIE	Middle	Last: GILHOOL		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 144-03-8060	17. INFORMANT: JOHN SCHROEDER - HUSBAND - SAME	Address			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Respiratory failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: sev. minutes

161.9

Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse lost.

DUE TO, OR AS A CONSEQUENCE OF (b): Esophageal-tracheal fistula with aspiration — sev. months

DUE TO, OR AS A CONSEQUENCE OF (c): Laryngeal and Bronchogenic carcinoma c metastases — 1 yr.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Pneumonitis, bilateral

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this haspital) attended the deceased from April, 1963, to Oct 14, 1969, that (I) ~~(we)~~ last saw the deceased alive an 10/14 1969, and that in (my) ~~(our)~~ opinion death accurred an the date and haur and fram the causes stated abave, (I) ~~(we)~~ ~~(did)~~ (did nat) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Jos H Mitchell	MD	☒	☐	☐	10/14/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
George H. Mitchell	11125 Rockville Pike, Rockville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
2 Burial	10-16-69	Gettysburg National Cem	Gettysburg		Penn

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Francis J. Collins 500 Univ. Blvd, W. Silver Spring, Maryland.	OCT 20 1969	J Charles Judge

VR A15 (4) 45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14652

CERTIFICATE OF DEATH

14650

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
ISABEL	LUCILLE	SCOTT	OCTOBER	20	1969	11:08 A.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
Female	Negro	6-1-12	57 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
~~South~~ D.C	United States	WIDOWED ☒	Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Takoma Park	Washington SAN + Hosp	Social worker	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
D.C.		Washington	YES ☒ NO ☐	7417 9th St N.W.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Isaac	Lipscomb		NINA	UREY	UREY

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
NO	578-14-9862	David L. Scott - 908-52nd St NE

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CEREBRAL HEMORRHAGE	4 DAYS.
DUE TO, OR AS A CONSEQUENCE OF (b)	HYPERTENSIVE AND ARTERIOSCLEROTIC VASCULAR DISEASE	20 YEARS
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

431.0

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from FEBRUARY, 1964, to OCT. 20, 1969, that (I) (we) last saw the deceased alive on OCT 20 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Robert L. Krichmar	MD	☑	☐	☐	OCT. 20 1969.

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
ROBERT L. KRICHMAR MD	7733 ALASKA AVENUE NW WASHINGTON DC 20012

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	10-25-69	Lincoln Memorial Cemetery	Suitland, Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
John T. Rhines Company Funeral Home 3015 12th Street, N. E.	OCT 24 1969	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

1

14653

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14651

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: Elizabeth	Middle: L.	Last: Sears.	2a. DATE OF DEATH Month: 10 Day: 18 Year: 69	2b. HOUR: 4:20 PM	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: 11-27-94	6. AGE (In years last birthday): 74 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country): Md.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Montgomery. Md.			
10. CITY OR TOWN OF DEATH: Bethesda.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Suburban	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Montgomery.	13c. CITY OR TOWN: Bethesda	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 7827 Custer Rd.		
14. FATHER'S NAME First: Abel	Middle	Last: Lamdin	15. MOTHER'S MAIDEN NAME First: Emma E	Middle	Last: McFarland.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT (SON): William Sears.	Address: 7809 Stafford Rd.			

MEDICAL CERTIFICATION

1B. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Abdominal carcinomatosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 months
157.9
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Primary Carcinoma of Pancreas — months
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (I) ~~(this hospital)~~ attended the deceased from September 1969, to Oct 18, 1969, that (I) ~~(we)~~ last saw the deceased alive on Oct 18 1969, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ ~~(did)~~ (did not) view the body after death.

22b. SIGNATURE: Robert N. Coale M D	DEGREE	ATTENDING PHYS. [X]	MED. DIRECTOR [ ]	STAFF PHYS. [ ]	22c. DATE SIGNED: Oct 18 1969
22d. PHYSICIAN'S NAME (Type): ROBERT N. COALE	22e. ADDRESS: 5411 Cedar Lane Bethesda Md				

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation	23b. DATE: 10/20/1969	23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Crematory	23d. LOCATION (City or Town) (County) (State): Bladensbury, Maryland	
24. FUNERAL DIRECTOR: Joseph Gawler's Sons Inc.	ADDRESS: 3030 WISC. AV WASH. D.C.	25a. REC'D BY REGISTRAR DATE: OCT 22 1969	25b. REGISTRAR'S SIGNATURE: J. Charles Judge	

VR A (5-1) 45M - 7-69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14654 14652

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First	Middle	Lost	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Gordon	Harris	Seger	October	12	1969	11:02 AM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
Male	White	3 July 1907	62 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Minnesota	USA		Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Bethesda	The Clinical Center, NIH	Administrator	U.S. Gov't.

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER
Maryland	Montgomery	Bethesda	YES X	7011 Armat Drive

14. FATHER'S NAME First	Middle	Lost	15. MOTHER'S MAIDEN NAME First	Middle	Lost
Edwin	W.	Seger	Lorena		Seger

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT
Yes	1942-45	370-05-8153	Bethesda, Maryland 20014 The Medical Records, The Clinical Center,

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Pulmonary emboli	days
DUE TO, OR AS A CONSEQUENCE OF (b)	Thrombophlebitis	
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if ony, which gove rise to immediote couse (a), stoting the underlying couse lost.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
Glioblastoma multiforme

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES X NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
			Yes

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	Stote

22a. **I certify** thot ~~I~~ (this hospital) ottended the deceased from 18 April, 1969, to 12 Oct., 1969, that ~~I~~ (we) last saw the deceased alive an 12 October 19 69, and that in ~~my~~ (our) opinian death occurred on the dote and hour and from the couses stoted above. ~~I~~ (we) (did) ~~did not~~ view the body ofter death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Sherman C Stein, MD		☐	☐	X	13 October 1969

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Sherman C. Stein, MD	The Clinical Center, National Institutes of Health, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (Stote)
CREMATION	10-14-69	CEDAR HILL CREMATORY	SUITLAND, PR.GEO. CO.MD.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
ROBERT A. PUMPHREY,	7557 WISCONSIN AVE. BETHESDA, MARYLAND.	OCT 17 1969	J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires thot the deoth certificate be executed within 24 hours after death. Page 4 may be retoined by the hospitol or ottending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician ond completely filled in by the funeral director, page 3 should be detoched for use os the burial-transit permit. Then please remove carbon papers. Pages 1 ond 2 should be filed with the State Dept. of Health prior to buriol, cremation, or removal, and in ony event, within 72 hours after death.

VR A15
45M - 1/69

14655

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14653

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: MARGARET	Middle:	Last: SEIBERT	2a. DATE OF DEATH: Month Oct. Day 17 Year 1969	2b. HOUR: 8:20 P M
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: 5-2-96	6. AGE (In years last birthday): 73 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): Md.	7b. CITIZEN OF WHAT COUNTRY?: AMERICA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: MONTGOMERY	Md.	
10. CITY OR TOWN OF DEATH: TAKOMA PARK	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): WASH. SAN. & HOSP.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: P. G.	13c. CITY OR TOWN: HYATTSVILLE	13d. INSIDE CITY LIMITS? YES [ ] NO [ ]	13e. STREET AND NUMBER: 6516 Medwick	
14. FATHER'S NAME First: AUSTIN	Middle:	Last: CHRISTNER	15. MOTHER'S MAIDEN NAME First: Lydia	Middle:	Last: ?
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT: HOSPITAL RECORDS.	Address	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Kidney Disease with Electrolyte Imbalance

4220

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Congestive Heart Failure

DUE TO, OR AS A CONSEQUENCE OF (c): Anemia

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4-5 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): (1) Chronic Azotemia (2) Staghorn Left Kidney (3) Micro-Nephritis (4) Chole-lithiasis (5) Small Stone

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County / State

22a. **I certify** that (I) (this hospital) attended the deceased from ____, 1946, to Oct 17, 1969, that (I) (we) last saw the deceased alive on Oct 17 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Alan R Gair	DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	22c. DATE SIGNED: 10/17/69	
22d. PHYSICIAN'S NAME (Type): Alan R Gair MD	22e. ADDRESS: 3118 Craiglawn Rd Beltsville Md.		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Oct 21. 1969	23c. NAME OF CEMETERY OR CREMATORY: George Washington	23d. LOCATION (City or Town): Adelphi	(County): Pr. Geo	(State): Md
24. FUNERAL DIRECTOR: Takoma Funeral Home Inc J.A. Wallace	ADDRESS: 254 Carroll St	25a. REC'D BY REGISTRAR DATE: OCT 22 1969	25b. REGISTRAR'S SIGNATURE: Florence Judge		

VR A15 (4) 45M - 11/69

1
FOR STATE HEALTH DEPT.

Items 18, 21a, 22a, Film CH18 11/1/69 ,cr

MARYLAND STATE DEPARTMENT OF HEALTH

14656

14654

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) First	Middle	Last
CHRISTOPHER	L.	SERVANT

2a. DATE KNOWN OF DEATH ESTIMATED ☐ Month 10 Day 3 Year 1969 — 2b. HOUR 6 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
MALE	WHITE	11/27/54	14 YRS.		

2c. DATE PRONOUNCED DEAD Month 10 Day 3 Year 19 69 — 2d. HOUR 6PM

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
WASH DC	USA	NEVER MARRIED X	MONTGOMERY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
SILVER SPRING	HOLY CROSS HOSP	MINOR	

13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	MONTGOMERY	ROCKVILLE	YES X NO ☐	935 GRADIN AVE

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
RENE		SERVANT	MARIA THERESE		LAGAIE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO	NONE	XXXX

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Fractured Skull with	
DUE TO, OR AS A CONSEQUENCE OF		
(b)	Intracranial Hemorrhage	
DUE TO, OR AS A CONSEQUENCE OF		
(c)		

814.7

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES X NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY X OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year (HOUR A.M. 4:10 P.M.)	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
	10-3 1969	Deceased was pedestrian when struck by auto

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK X	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION (Street or R.F.D. No.)	City or Town	County	State
	Street	935 Avery Rd near Lynes Rd	Montgom	Md	

22a. **I certify** that I took charge of the remains described above, held an Autopsy X, Inspection X, Inquiry X, and in my opinion death resulted from: Natural causes ☐, Accident X, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Belden R. Reap M.D.

EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER X

ADDRESS (Street, city, town or county) Wheaton

22b. DATE SIGNED OCT. 3, 1969

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	10/7/69	Southern Memorial Cem.	Dunkirk, Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Tyson Wheeler Funeral Home 1331 Rock. Pike Rockville, Maryland	OCT 9 1969	Charles Judge

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any questions necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M - 1/69

1

FOR STATE HEALTH DEPT.

Items 18, 22a
Film G 419, 12/5/69, cr

MARYLAND STATE DEPARTMENT OF HEALTH

14655

14657

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with an N.Y. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, crematian, ar removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ Month	Day	Year	2b. HOUR
Wilbert	Curtis	Seymour	10-	21	69	10 45 A M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS	DAYS	IF UNDER 24 HRS: HOURS	MIN	2c. DATE PRONOUNCED DEAD Month	Day	Year	2d. HOUR
₩ Male	Wh	11-9-00	68 YRS.					10	21	1969	10 45 A M

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
~~Canada~~ N.Y.	US		Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Takoma Park	Washington San & Hosp		

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER
Md.	Mont.	Silver Spring		15005 Argyle Club Rd.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Rubin		Seymour	Mary		Curtis

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
	578 20 8131	MRS. GLADYS C. SEYMOUR (SAME AS 13E)

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary thrombosis

410.9

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Manth, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 ar Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At hame, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** thot I took charge of the remains described above, held an Autapsy ☒, Inspection ☒, Inquiry ☒, and in my apinian death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Belden R. Reap M.D.

EXAMINER'S NAME (Type) BELDEN R. REAP M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ADDRESS (Street, City, Town, or county) Frederick

22b. DATE SIGNED Oct. 21, 1969

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Oct 24. 1969	Cedar Hill Cemetery	Newburgh New York

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Takoma Funeral Home J. Arthur Walters	254 Carroll St. N.E. Wash. D.C. 20012	OCT 27 1969	Charles Judge

VR A15ME (5)
10M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14658 14656

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First	Middle	Lost	2o. DATE OF DEATH Month Doy Year	2b. HOUR
THEODORE	EUGENE	SHACKELFORD	OCTOBER 2 1969	8:16 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In yeors last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
MALE	CAUCASIAN	30 DECEMBER 1918	50 YRS.		

7o. BIRTHPLACE (Stote or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
	U.S.		MONTGOMERY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12o. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
BETHESDA	NAVAL HOSPITAL		

13o. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
VIRGINIA		CHANTILLY	YES ☐ NO ☐	4202 DEHAVEN DRIVE

14. FATHER'S NAME First	Middle	Lost	15. MOTHER'S MAIDEN NAME First	Middle	Lost
WILLIAM	WARREN	SHACKELFORD	MARGARET	LOUISE	

16o. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
YES	II	484 01 4132	WIFE	4202 DEHAVEN DR., CHANTILLY, V

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (o), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (o) ACUTE OCCLUSION LEFT DESCENDING ANTERIOR CORONARY ARTERY.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)

19o. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
			YES

21o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	Stote

22a. **I certify** that (I) (this hospital) attended the deceased from 29 SEP, 19 69, to 2 OCT, 19 69, that (I) (we) last saw the deceased alive on 2 OCT 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
J. F. Ansbro M.D.			☐	☑	30 Oct 1969

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
J. F. ANSBRO, M.D.	NAVAL HOSPITAL, BETHESDA, MD.

23o. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Oct 7, 1969	ARLINGTON NATIONAL	ARLINGTON VIRGINI

24. FUNERAL DIRECTOR ADDRESS	25o. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
David W. Crandell EVERLY FUNERAL HOME, FAIRFAX, VIRGINIA 22030	OCT 6 1969	Florence Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physicion and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

1

14659

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14657

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Dr. Reap Notified & will approve. 10/1/68

3200

1. DECEASED-NAME (Type or print)	First: PHILIP	Middle: M.	Last: SHELLEY	2a. DATE OF DEATH Month: 10 Day: 1 Year: 69	2b. HOUR: 5:35 P.M.		
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: 11-14-67	6. AGE (In years last birthday): 1 YR 11 MOS YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.		
7a. BIRTHPLACE (State or foreign country): MD.	7b. CITIZEN OF WHAT COUNTRY?: U.S	8. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: MONT. Md.				
10. CITY OR TOWN OF DEATH: SILVER SPRING	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): HOLY CROSS HOSP	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): INFANT	12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD.	13b. COUNTY: ~~MONT. USA~~	13c. CITY OR TOWN: ROCKVILLE	13d. INSIDE CITY LIMITS? YES ☑ NO ☐	13e. STREET AND NUMBER: 16641 FRONTENAC TR.			
14. FATHER'S NAME First: PHILIP	Middle: E	Last: SHELLEY	15. MOTHER'S MAIDEN NAME First: PATRICIA	Middle:	Last:		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT: DR. PHILIP E. SHELLEY	Address: SAME AS #13				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac AND RESPIRATORY FAILURE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 HR
DUE TO, OR AS A CONSEQUENCE OF
(b): PROBABLE BRAINSTEM + MIDBRAIN INVOLVEMENT — ? 12-24 HRS.
DUE TO, OR AS A CONSEQUENCE OF
(c): FULMINANT BACTERIAL MENINGITIS — DUE TO HEMOPHILUS INFLUENZA TYPE B
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☑ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from OCT. 1, 19 69, to OCT 1, 19 69, that (I) (we) last saw the deceased alive on OCT. 1 1969, and that in (my) (our) opinion death occurred on the date and hour and from the couses stated abave (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Frank A. Pedreira, M.D.		☐	☐	☑	OCT. 2, 1969

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
FRANK A. PEDREIRA, M.D.	10401 OLD GEORGETOWN RD., BETHESDA, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Cremation	10/3/69	Lees Crematory	Washington,	D. C.	

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
J. Wm. Lees Sons, Co.,	300 4th St., NE Washington, DC	OCT 6 1969	Elizabeth Judge

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14660 — 14658

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print): First (MAGGIE) MARGARET Middle MARSHALL Last Shelton
2a. DATE OF DEATH: Month October Day 5 Year 1969
2b. HOUR: M
3. SEX: FEMALE
4. RACE: NEGRO
5. DATE OF BIRTH: NOV 4, 1872
6. AGE (In years last birthday): 96 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN
7a. BIRTHPLACE (State or foreign country): Virginia
7b. CITIZEN OF WHAT COUNTRY?: U.S.A
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
9. COUNTY OF DEATH: MONTGOMERY Md.
10. CITY OR TOWN OF DEATH: MONT Rockville
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Potomac Valley N.H.
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): House wife
12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD
13b. COUNTY: MONT
13c. CITY OR TOWN: Rockville
13d. INSIDE CITY LIMITS? YES ☑ NO ☐
13e. STREET AND NUMBER: 612 N. Horners Lane
14. FATHER'S NAME First JOHN Middle Lost WOOD
15. MOTHER'S MAIDEN NAME First Polly Middle ? Lost JOHNSON
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or (unknown) NO (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: 216-10-1043D
17. INFORMANT: Mrs. Marilyn Claggett (daughter) Address (SAME)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 15'
410.9
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Coronary thrombosis — 24 hrs
DUE TO, OR AS A CONSEQUENCE OF (c): Coronary Arteriosclerosis — Indefinite
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
1) Ca of Stomach 2) Anemia 3) Prolapse uteri
19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 1/10, 19 35, to 10/3, 19 69, that (I) (we) last saw the deceased alive on 10/3/1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 10/5/69
22d. PHYSICIAN'S NAME (Type)
22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 10/9/69
23c. NAME OF CEMETERY OR CREMATORY: Lincoln Park Cem.
23d. LOCATION (City or Town) (County) (State): Rockville, Montg., Md.
24. FUNERAL DIRECTOR ADDRESS: Robert L. Snowden Rockville, Md.
25a. REC'D BY REGISTRAR DATE: OCT 10 1969
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-73
45M - 7-68

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Exominer's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File poges 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

4123

14661

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14659

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE KNOWN OF DEATH / ESTIMATED	Month Day Year	2b. HOUR
HARRY	L.	SHENK	☒ / ☐	10-1-69 19	11 AM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN	2c. DATE PRONOUNCED DEAD Month Day Year	2d. HOUR
Male	Cauc.	July 2, 1893	76 YRS.			10-1-69 19	11 AM

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
New York	U. S. A.		Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Bethesda	Suburban Hospital	Claims Examiner	U.S. Gov't

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER
Md.	Montg.	Chevy Chase		4730 Bradley Blvd.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Jacob		Shenk	Fannie		?

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	---	Unknown	Ann J. Shenk,	Same as 10

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute Coronary Insufficiency	
DUE TO, OR AS A CONSEQUENCE OF (b)	Coronary Artery Heart Disease	
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Pulmonary Emphysema

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Belden R. Reap M.D.

EXAMINER'S NAME (Type): BELDEN R. REAP, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, Town, or county): Wheaton, Md.

22b. DATE SIGNED: 10/1/69

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	10-3-1969	B'nai Israel Cemetery	Oxon Hill Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Goldberg Funeral Home 4217 9th St., N.W.	OCT 3 1969	Charles Judge

VR A15ME (5)
10M REV. 1/68

1

14662

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14660

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
FLORA	VICTORIA	SHOEMAKER	October 12 1969	8:40p M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
Female	Caucasian	December 29, 1893	75 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
~~Virginia~~ Md.	United States		Montgomery County Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Olney	Montgomery General Hospital	Housewife	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER
Maryland	Montgomery	Gaithersburg		14510 Dufief Mill Road

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Ernest		Kidwell	Katie		Hart

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
No		218 24 2442	Mr. James Shoemaker	Dufief Mill Rd. Gaithersburg, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carcinomatosis, intra-

DUE TO, OR AS A CONSEQUENCE OF (b) abdominal

DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of Colon

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

153.8

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: (a) Months; (c) ?

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Diabetes Mellitus mild.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that (I) (this hospital) attended the deceased from 1951, 19___, to Oct 12, 1969, that (I) ~~(we)~~ last saw the deceased alive on Oct. 12 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Jack Schumacher	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	10-13-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Jack Schumacher, M. D.	Russell Ave. Gaithersburg, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Oct. 17, 1969	Frederick Mem. Pk.	Frederick, Maryland

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Tyson Wheeler Funeral Home	1831 Rockville Pike Rockville, Maryland	OCT 14 1969	J. Charles Judge

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14663 14661

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Dinah	Lynn	Short	October 27 1969	3:30 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Female	White	5 July 1951	18 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Virginia	USA	NEVER MARRIED [X]	Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Bethesda	The Clinical Center, NIH	Student	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Virginia	Dickenson	Clintwood	YES [ ] NO [X]	Route # 2

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Burl	T.	Short	Amy	-	Baker

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
No	--	Not Available	Bethesda, Md. 20014 The Medical Records, The Clinical Center,

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
446.3	IMMEDIATE CAUSE (a) Cardiorespiratory arrest	Immediate
	DUE TO, OR AS A CONSEQUENCE OF (b) Lung abscess	3 weeks
	DUE TO, OR AS A CONSEQUENCE OF (c) Wegener's granulomatosis	15 Months

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [X] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
			Yes

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that (X) (this hospital) attended the deceased from 15 October, 1969, to 27 October 1969, that (X) (we) last saw the deceased alive on 27 October 1969, and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.

22b. SIGNATURE (DEGREE)	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Larry G. Anderson, M.D.	[ ]	[ ]	[X]	27 October 1969

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Larry G. Anderson, M.D.	The Clinical Center, National Institutes of Health, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	10-29-69	Family Cemetery	Clintwood Dixon Virginia

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Tyson Wheeler F.H. Rockville Maryland 1331 Rockville Pike	OCT 29 1969	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

FOR STATE HEALTH DEPT.

14664

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14662

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) First	Middle	Last
ALMA	H.	SILSBY

2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☐ Month 10 Day 1 Year 1969 — 2b. HOUR M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
FEMALE	WHITE	JULY 3,1900	69 YRS.		

2c. DATE PRONOUNCED DEAD Month 10 Day 1 Year 1969 — 2d. HOUR 7:12 A M

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
MICHIGAN	U.S.A.		MONTGOMERY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
BETHESDA	SUBURBAN HOSPITAL	HOMEMAKER	OWN HOME

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MICH.	WAYNE	REDFORD TSP.	YES ☒ NO ☐	11408 FENTON

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
ALBERT		HECHT	JOHANNA		(UNKNOWN)

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT
NO	****	NOT AVAIL.	MR. OLIVER SILSBY, CHEVY CHASE, MD. 7505 CONNECTICUT AV

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary insufficiency — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Coronary Artery Heart Disease
DUE TO, OR AS A CONSEQUENCE OF
(c)

4123

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Belden R. Reap M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED 10-1-69

EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.

ADDRESS (Street, city, town, or county) 7505 CONNECTICUT AVE. MONTGOMERY CO. MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	10-4-69	GRAND LAWN CEMETERY	DETROIT, WAYNE CO. MICHIGA

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
ROBERT A. PUMPHREY, 7557 WISCONSIN AVE. BETHESDA, MARYLAND	OCT 6 1969	J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DH-43. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14665

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14663

1. DECEASED-NAME (Type or Print)	First: Timothy	Middle: William	Last: Skellchock	2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ]	Month: 10	Day: 11	Year: 1969	2b. HOUR: 2P. M			
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: 9/24/1949	6. AGE (In years last birthday): 20 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD: Month 10 Day 11 Year 1969	2d. HOUR: 2P. M				
7a. BIRTHPLACE (State or foreign country): New York	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Montgomery Md.								
10. CITY OR TOWN OF DEATH: McComas	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Rt. 109 McComas, Md.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Student	12b. KIND OF BUSINESS OR INDUSTRY: School								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Silver Spring	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 611 Valley Brook Drive							
14. FATHER'S NAME First: Dr. Joseph	Middle: P.	Last: Skellchock	15. MOTHER'S MAIDEN NAME First: Edith	Middle:	Last: Hertfelder						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No	(If yes give war or dates of service): - - - -	16b. SOCIAL SECURITY NO.: 219-54-6788	17. INFORMANT: Father	ADDRESS: Silver Spring, Md. Dr. Joseph P/ Skellchock-611 Valley Brook Dr.							

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Multiple injuries

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. / P.M.: 2 P.M. 10 11 1969	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.): Passenger in airplane crash

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
		Rt. 109	McComas		Md.

22a. **I certify** that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Werner U. Spitz, M.D. M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [ ]

Deputy Chief Medical Examiner

22b. DATE SIGNED: 10-12-69

ADDRESS (Number, Street, City or Town, State): 8434 Georgia Avenue, Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	10/15/69	Parklawn Cemetery	Rockville, Montgomery, Maryland

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
P. Smith P. Smith Warner E. Pumphrey, Inc.,	8434 Georgia Avenue Silver Spring, Md.	OCT 16 1969	Charles Judge

VR A15ME (5) 10M REV. 1/68

Items 19a &19b, Film 417
10/14/69 cr

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14664

CERTIFICATE OF DEATH

14666

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Preston	(NMN)	Skinner	October 2 1969	5:47 A M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
Male	White	5 May 1936	33 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARITAL STATUS	9. COUNTY OF DEATH
New York	USA	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Bethesda	The Clinical Center	Forest Conservation	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
New York	Oneida	Camden	YES [X] NO [ ]	River Road, R. D. #3

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Henry		Skinner	Nellie		LaDuke

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
No	133-28-1521	The Medical Records The Clinical Center, NIH, Bethesda, Md. 20014

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Myocardial failure	12 hours
DUE TO, OR AS A CONSEQUENCE OF (b)	Aortic, mitral & tricuspid valve replacement	16 days
DUE TO, OR AS A CONSEQUENCE OF (c)	Rheumatic heart disease	years

396.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Hepatic failure

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
9/16/69	Rheumatic heart disease	YES [X] NO [ ]	yes

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that XX(this hospital) attended the deceased from 1 Sep. , 19 69, to 2 Oct. , 19 69, that X (we) last saw the deceased alive on 2 October 19 69, and that in XXX(our) opinion death occurred on the date and hour and from the causes stated above, X (we) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Charles L McIntosh, M.D.		[ ]	[ ]	[X]	October 2, 1969

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Charles L. McIntosh, M.D.	The Clinical Center, The National Institutes of Health, Bethesda, Md. 20014

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
10-5-69	10-5-69	FOREST LAWN CEMETERY	CAMDEN, ONEIDA CO. N.Y.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
ROBERT A. PUMPHREY, 7557 WISCONSIN AVE, BETHESDA, MARYLAND.	OCT 6 1969	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

14665

Preston (RRN) Skinner October 2 1969 5:47

Male White 5 May 1936 33

New York USA x Montgomery

Bethesda The Clinical Center Forest Conservation

New York Oneida Camden x River Road, R. D. 33

Henry Skinner Nellie Lahuke

The Medical Records

No 133-28-1521 The Clinical Center, NIH, Bethesda, MD. 20014

Myocardial failure 14 hours

Aortic, mitral & tricuspid valve replacement 16 days

Rheumatic heart disease years

Hepatic failure

XX Yes

X 2 October 69 1 Nov. 69 2 Oct. 69 X

X XXXX XXX

X October 2, 1969

The Clinical Center, The National

Charles L. McIntosh, M.D. Institutes of Health, Bethesda, MD. 20014

10-5-69 10-5-69 FOREST LAWN CEMETERY CAMDEN, ONEIDA CO. N.Y.

7557 WISCONSIN AVE.

ROBERT A. PUMPHREY, BETHESDA, MARYLAND

13 1

14667

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14665

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: Selden	Middle: Clobridge	Last: SMALL	2a. DATE OF DEATH: Month October Day 28 Year 69	2b. HOUR: 1045 PM
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH: Jan. 21, 1910	6. AGE (In years last birthday): 59 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): New York	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Montgomery Md.		
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Naval Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): U. S. Navy	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Virginia	13b. COUNTY: Stafford	13c. CITY OR TOWN: Falmouth	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER: Route 5, Box 520	
14. FATHER'S NAME First: Matthew	Middle:	Last: Small	15. MOTHER'S MAIDEN NAME First: Emily	Middle:	Last: Clobridge
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: Yes	(If yes give war or dates of service): 1932-1962	16b. SOCIAL SECURITY NO.: Not Avail.	17. INFORMANT: Hospital records	Address:	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

171.9

IMMEDIATE CAUSE (a): Myxoid Liposarcoma with widespread

DUE TO, OR AS A CONSEQUENCE OF: metastases

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b):

DUE TO, OR AS A CONSEQUENCE OF

(c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [X] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, natify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County / State

22a. **I certify** thot (I) (this hospital) attended the deceased from Sept. 8, 1969, to Oct. 28, 1969, that (I) (we) lost saw the deceased alive an Oct. 28 1969, and thot in (my) (aur) apinian death accurred on the date and hour ond from the causes stated above, (I) (we) (did) (did not) view the body after deoth.

22b. SIGNATURE: S. A. Grzenda M.D.	DEGREE	ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]	22c. DATE SIGNED: Oct. 29, 1969
22d. PHYSICIAN'S NAME (Type): S. A. GRZENDA, M. D.	22e. ADDRESS: Naval Hospital, Bethesda, Md.		

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation	23b. DATE: 10-29-69	23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory	23d. LOCATION (City or Town): Suitland	(County) (State): Md.
24. FUNERAL DIRECTOR ADDRESS: Robert A. Pumphrey Funeral Home, 7557 Wisconsin Ave. Bethesda, Md.		25a. REC'D BY REGISTRAR DATE: OCT 30 1969	25b. REGISTRAR'S SIGNATURE: [illegible] Judge	

VR A15 (4) 45M 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14668 14666

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Larry	W.	Smarr	18 October 1969	9:45 AM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
Male	White	24 May 1957	12 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Virginia	U.S.A.		Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Bethesda	The Clinical Center, NIH	Student	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Virginia	Fairfax	Alexandria	YES ☐ NO ☒	6415 Edsal Road

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Irving	L.	Smarr, Sr.	Joyce		Tolson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	None	The Medical Record	The Clinical Center, NIH, Bethesda, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Metastatic Ewings Sarcoma, primary right humerus — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 8 months

DUE TO, OR AS A CONSEQUENCE OF (b)

Conditians, if ony, which gave rise to immediate couse (a), stating the underlying couse last. — DUE TO, OR AS A CONSEQUENCE OF (c)

170.4

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
			Yes

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 ar Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at wark ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street ar R.F.D. No.	City ar Town	County	State

22a. **I certify** that ☒ (this hospital) attended the deceased from 9 September 1969, to 18 Oct., 1969, that ☒ (we) last saw the deceased alive an 18 October 1969, and that in ☒ (aur) apinian death accurred an the date and haur and fram the causes stated abave, ☒ (we) (did) (~~did not~~) view the bady after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Gerald W. Marsa, M.D.		☐	☐	☒	18 October 1969

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Gerald W. Marsa, M.D.	The Clinical Center, National Institutes of Health, Bethesda, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	10/21/69	National Memorial Park	Falls Church, Virginia

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
S E Davis Cunningham Funeral Home, Inc.	Alex., Va.	OCT 22 1969	Jolanta Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

14665

Larry M. Smart 18 October 1959 9:48

Male White 24 May 1957 18

Virginia U.S.A. Montgomery

Bethesda The Clinical Center, NIH Student

Virginia Fairfax Alexandria XX 6415 Edsall Road

Irving L. Smart, Sr. Joyce Tolson

The Medical Record

No Home The Clinical Center, NIH, Bethesda, Maryland

Numerus

Metastatic Kwings Sarcoma, primary right 8 months

Yes

18 October 59 September 59 18 Oct. 59 X

x 18 October 1959

The Clinical Center, National Institutes of Health, Bethesda, Maryland

Gerald W. Norris, M.D.

Burial 10/21/59 National Memorial Park Falls Church, Virginia

Cunningham Funeral Home, Inc. Alex., Va.

1

14669

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14667

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
LEAH	CLARISSA	SMITH	OCTOBER 5, 1969	5:50 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
Female	Caucasian	26 SEPT. 1969	NA YRS.	9	

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
ANDREWS AFB	USA		MONTOGOMERY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
BETHESDA	NAVAL HOSPITAL	NONE	NA

13a. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	P.G.	BRANDYWINE	YES ☐ NO ☐	HOME PARK 1017 CEDARVILLE MOBILE

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
ALVIN LELAND SMITH			DOROTHY ANN MCGUINE		

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO		NA	ALVIN L. SMITH	HOME PARK 1017 CEDARVILLE MOBILE

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Transposition of great vessels — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

(b) Congenital heart disease

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gove rise to immediote couse (a), stoting the underlying couse last.

7461

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
			Yes

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from Sept. 30, 1969, to Oct. 5, 1969, that (I) (we) last saw the deceased alive an Oct. 5 1969, and that in (my) (our) apinian death accurred an the date and haur and fram the causes stated abave, (I) (we) (did) ~~(did not)~~ view the bady after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Mark N Goldschmidt, MD		☐	☐	☒	Oct 6, 1969

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Mark N. GOLDSCHMIDT M.D.	Naval Hospital, Bethesda

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	10-8-69	ST. MARY'S CHURCH	BATH		NEW YORK

24. FUNERAL DIRECTOR ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
ROBERT A. PUMPHREY FUNERAL HOME, BETHESDA, MD.	OCT 8 1969	

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14670

14668

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removol, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Vivian	Loretta	Smith	October 28, 1969	5:20 A M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Female	White	20 November 1945	23 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Indiana	USA	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Bethesda	The Clinical Center	Housewife	

13a. USUAL RESIDENCE (Where deceased lived, if institutian: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Indiana	Henry	New Castle	YES [X] NO [ ]	1101 South 25th Street

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Arthur		Hoover	Pauline		McNeese

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
No	566-64-6347	The Medical Records The Clinical Center, NIH, Bethesda, Md. 20014

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pulmonary Edema — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 12 Hours

394.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Rheumatic Heart Disease with Mitral Stenosis — Years

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Multiple Pulmonary Emboli

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
10-24-69	Mitral Stenosis	YES [X] NO [ ]	Yes

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medicol examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that [X] (this hospital) attended the deceased from 1 July, 1969, to 28 Oct., 1969, that [X] (we) last saw the deceased alive on 28 October 1969, and that in [XX] (our) opinian death occurred on the date and haur and from the causes stated abave, [X] (we) (did) ([XXXX]) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Edward Jacobs Jr. M.D.	M.D.	[ ]	[ ]	[X]	28 October 1969

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Edward Jacobs Jr., M.D.	The Clinical Center, The National Institutes of Health, Bethesda, Md. 20014

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
REMOVAL	10-28-69	SOUTHMOUND CEMETERY	NEW CASTLE, HENRY, INDIANA

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
ROBERT A. PUMPHREY, 7557 WISCONSIN AVE., BETHESDA, MARYLAND	OCT 30 1969	J. Charles Judge

VR A15 (4)
45M - 1/69

14670

1

14671

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14669

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Lorene Catherine	Sompayrac		10	5	69	5:30AM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN
Female	White	1-2-12	57 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Kansas	US		Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Olney	Montgomery General	Hwf.	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Montgomery	Silver Spg.	YES ☐ NO ☒	3301 S.Leisure Wld.Blvd.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Fred B.		Burg	Bessie		Barker

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
no	578-01-9792	Powell L. Sompayrac-Item # 13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Multiple Cerebral Hemorrhage	5 days.
DUE TO, OR AS A CONSEQUENCE OF (b)	Hypertensive Cardiovascular Disease	5 yrs.
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4/22

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES ☒ NO ☐	Yes.

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) ~~(this hospital)~~ attended the deceased from Jan 65, 19__, to Oct 5, 19 67, that (I) ~~(we)~~ lost saw the deceased alive an Oct 4 19 69, and that in (my) ~~(our)~~ opinion death occurred an the date and haur and fram the causes stated abave, (I) ~~(we)~~ (did) ~~(did not)~~ view the bady after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED
Richard A. Yates M.D.					10/5/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Richard A. Yates, M.D.	Olney, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	10/8/69	National Memorial Park	Falls Church, Virginia

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville,Md.	OCT 9 1969	J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14672 14670

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print): First SAM Middle SHAE Last SOROKA
2a. DATE OF DEATH: Month 10 Day 14 Year 69
2b. HOUR: 5:40 PM
3. SEX: M
4. RACE: Wh.
5. DATE OF BIRTH: 2/12/89
6. AGE (In years last birthday): 80 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (State or foreign country): RUSSIA
7b. CITIZEN OF WHAT COUNTRY?: U. S. A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. COUNTY OF DEATH: MONTGOMERY Md.
10. CITY OR TOWN OF DEATH: SILVER SPRING
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): HOLY CROSS
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Musician
12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland
13b. COUNTY: Montgomery
13c. CITY OR TOWN: Silver Spring
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 10118 Hereford Place
14. FATHER'S NAME First: Raymond Middle: Lost: Soroka
15. MOTHER'S MAIDEN NAME First: Leah Middle: Lost: (Unknown)
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: 578-26-0285A
17. INFORMANT Address: Herbert Soroka 10204 Leslie St. Silver Spring

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive heart failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 week
DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic Heart Disease — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Diabetes mellitus; chronic bronchitis & emphysema

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While ☐ at work Not while ☐ at work
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) ~~(this hospital)~~ attended the deceased from May, 1965, to 10-14, 1969, that (I) ~~(we)~~ last saw the deceased alive on 10-13 1969, and that in (my) ~~(our)~~ opinion death occurred on the date and haur and from the causes stated above, (I) ~~(we)~~ (did) ~~(did not)~~ view the body after death.

22b. SIGNATURE: John Geiger, M.D. DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 10-14-69
22d. PHYSICIAN'S NAME (Type): JASON GEIGER, M.D.
22e. ADDRESS: 8830 CAMERON STREET SILVER SPRING MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 10-15-69
23c. NAME OF CEMETERY OR CREMATORY: Mount Lebanon Cemetery
23d. LOCATION (City or Town): Hyattsville (County): P.G. (State): Md.
24. FUNERAL DIRECTOR: Donald M. Stein Hebrew ~~Memorial~~ Funeral Home
ADDRESS: 232 Carroll St. NW Wash
25a. REC'D BY REGISTRAR DATE: OCT 20 1969
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (R)
45M - 1-69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14671

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First: EDWARD | Middle: WOODROW | Last: STEELMAN

2a. DATE OF DEATH: Month 10 Day 6 Year 69

2b. HOUR: 9:40AM

3. SEX: MALE

4. RACE: WHITE

5. DATE OF BIRTH: 1-15-15

6. AGE (In years last birthday): 54 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.

7a. BIRTHPLACE (State or foreign country): VIRGINIA

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. COUNTY OF DEATH: MONTGOMERY Md.

10. CITY OR TOWN OF DEATH: OLNEY

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress): MONTGOMERY GENERAL

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): INSTRUCTOR

12b. KIND OF BUSINESS OR INDUSTRY: MONTG. CO SCHOOL

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND

13b. COUNTY: MONTGOMERY

13c. CITY OR TOWN: ROCKVILLE

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET AND NUMBER: 1304 VEIRS MILL RD.

14. FATHER'S NAME First: JOHN | Middle: - | Last: STEELMAN

15. MOTHER'S MAIDEN NAME First: JENNY | Middle: - | Last: CARTER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO

16b. SOCIAL SECURITY NO.: 233 07 7439

17. INFORMANT Address: MEDICAL RECORD DEPT.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cerebral Embolus — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 27 hrs

DUE TO, OR AS A CONSEQUENCE OF

(b): Myocardial Infarction, Acute — 3 days

DUE TO, OR AS A CONSEQUENCE OF

(c): Arteriosclerotic Heart disease — yrs

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)

21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f. LOCATION Street or R.F.D. No. | City or Town | County | State

22a. I certify that (I) (this hospital) attended the deceased from 3/14, 1967, to 10/6, 1969, thot (I) (we) last saw the deceased alive on 10/6, 1969, and that in (my) (our) apinion death accurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.

22b. SIGNATURE: C. H. Ligon M.D. DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22c. DATE SIGNED: 10/6/69

22d. PHYSICIAN'S NAME (Type): C. H. LIGON, M. D.

22e. ADDRESS: MEDICAL CENTER, SANDY SPRING, MD. 20860

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 10/9/69

23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Mem. Gardens

23d. LOCATION (City or Town) (County) (State): Frederick, Maryland

24. FUNERAL DIRECTOR ADDRESS: Tyson Wheeler Funeral Home 1221 Rock. Pike Rockville, Maryland

25a. REC'D BY REGISTRAR DATE: OCT 9 1969

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M - 1/69

1
FOR STATE HEALTH DEPT.

Items 18&22a Film 421 2-13-70 ams

14674

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14672

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE KNOWN OF DEATH ESTIMATED ☒	Month	Day	Year	2b. HOUR
SHERRI	LYNN	STEIB		OCT	11	1969	9:50 A

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS	DAYS	IF UNDER 24 HRS.: HOURS	MIN.	2c. DATE PRONOUNCED DEAD: Month	Day	Year	2d. HOUR
FEMALE	CAUC	17 NOV 1968	YRS.	10	6			OCT	11	1969	9:50 A

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
MARYLAND	U.S.		MONTGOMERY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
BETHESDA	NAVAL HOSPITAL		

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
VIRGINIA		ALEXANDRIA	YES ☒ NO ☐	523 IMBODEN ST.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
JAMES	ANDREW	STEIB	ELDONNA	BETH	PLUCKER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		JAMES A. STEIB	523 IMBODEN ST. ALEXANDRIA, VA.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Liver Failure	Days
DUE TO, OR AS A CONSEQUENCE OF		
(b)	Reyes Syndrome Etiology undetermined	
DUE TO, OR AS A CONSEQUENCE OF		
(c)		

347.9
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES XX NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Naturol couses ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined monner ☐

ACTUAL SIGNATURE John G. Ball M.D.

EXAMINER'S NAME (Type) JOHN G. BALL ~~BRADENxRXXREAR~~, M.D. ~~BETHESDA MD~~ (Address: City, Town, or county)

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER XX

22b. **DATE SIGNED** 11 OCT 69

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
BURIAL	14 OCT 69	GERMANTOWN CEMETERY	CHANCELLOR		S. DAKOTA

24. FUNERAL DIRECTOR	ADDRESS	25a. FILED BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
FALLS CHURCH FUNERAL HOME	502 W. BORAD FALLS CHURCH, VA.	OCT 17 1969	Charles Judge

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PMS-1 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M - 1/69

1

14675

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14673

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First: John Middle: Eric Last: Stephens	2a. DATE OF DEATH Month: October Day: 16 Year: 1969	2b. HOUR 10:40 P.M.	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: October 15, 1969	6. AGE (In years last birthday) YRS. IF UNDER 1 YEAR MONTHS / DAYS: 1 IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery Md.
10. CITY OR TOWN OF DEATH: Silver Spring	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Holy Cross Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Wheaton	13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET AND NUMBER: 11914 Centerhill St			
14. FATHER'S NAME First: Clair Middle: John Last: Stephens	15. MOTHER'S MAIDEN NAME First: Delores Middle: Jean Last: Brewster		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: NONE	17. INFORMANT: mother - Address: Same	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac failure

746.9

DUE TO, OR AS A CONSEQUENCE OF (b) Congenital Heart Dis

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (I) (this hospital) attended the deceased from 10-15, 1969, to 10-16, 1969, that (I) (we) last saw the deceased alive on 10-16- 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Herbert J Jacobs MD DEGREE	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 10/16/69	
22d. PHYSICIAN'S NAME (Type): Herbert Jacobs	22e. ADDRESS: 2401 Blueridge Ave Wheaton Md		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Oct 18, 1969	23c. NAME OF CEMETERY OR CREMATORY: St. Stanislaus	23d. LOCATION (City or Town) (County) (State): Baltimore Md.
24. FUNERAL DIRECTOR: John J. Duda	ADDRESS: 7922 Wise Ave. Balt. Md. 21222	25a. REC'D BY REGISTRAR DATE: OCT 21 1969	25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15(4) 30M REV. 1/68

1 R

14676

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14674

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First: Lillie Middle: Ann Last: Stevenson	2a. DATE OF DEATH Month Day Year: Oct. 14 1969	2b. HOUR: 11:55 P M	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: 2/18/95	6. AGE (In years last birthday): 74 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): North Carolina	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery Md.
10. CITY OR TOWN OF DEATH: Olney	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Montgomery General Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): housewife	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Germantown	13d. INSIDE CITY LIMITS? YES ☐ NO ☒ 13e. STREET AND NUMBER: Route 1
14. FATHER'S NAME First Middle Last: John Davidson		15. MOTHER'S MAIDEN NAME First Middle Last: Rosie Lovingood	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): no (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Records Address: Montgomery General Hospital, Olney, M. D.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute pulmonary edema	6 hours
DUE TO, OR AS A CONSEQUENCE OF (b)	HASCUD	
DUE TO, OR AS A CONSEQUENCE OF (c)		

412.2

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Obesity, Diabetes mellitus.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. I certify that (I) (~~this hospital~~) attended the deceased from Oct 14, 1969, to _____, 19____, that (I) (~~we~~) last saw the deceased alive on Oct. 14 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~did~~) (did not) view the body after death.

22b. SIGNATURE: Frederick Moomau DEGREE ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒		22c. DATE SIGNED: 10-15-69
22d. PHYSICIAN'S NAME (Type): Frederick Moomau, M. D.	22e. ADDRESS: Medical Center, Sandy Spring, Md.	

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Oct.18,1969	23c. NAME OF CEMETERY OR CREMATORY: Forest Lawn	23d. LOCATION (City or Town) (County) (State): Enka, N.C.
24. FUNERAL DIRECTOR ADDRESS: Olin L. Molesworth, Damascus, Md.		25a. REC'D BY REGISTRAR DATE: OCT 20 1969	25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared with medical examiner

VR A15 (4)
45M - 1/69

Item#1,14,Film#17 10/2/76 S

14677

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14675

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death unless any deloy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) First: LeRoy Middle: Royal Lost: Stewart Jr				2a. DATE KNOWN OF DEATH ESTIMATED: Month 10 Day 12 Year 1969	2b. HOUR 12 PM
3. SEX: M.	4. RACE: W.	5. DATE OF BIRTH: April 2 1941	6. AGE (In years last birthday): 28 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.	2c. DATE PRONOUNCED DEAD: Month Oct Day 12 Year 1969	2d. HOUR 12 31 PM
7a. BIRTHPLACE (State or foreign country): Mass.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery Md.		
10. CITY OR TOWN OF DEATH: Beallsville.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Woods - ff Route 109	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Carpenter	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Va.	13b. COUNTY: Fairfax.	13c. CITY OR TOWN: Fairfax.	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 3838 Florence Drive.	
14. FATHER'S NAME First: LeRoy Middle: Royal Lost: Stewart, Sr.		15. MOTHER'S MAIDEN NAME First: Eidith Middle:	Lost: Collier.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 016-32-5358	17. INFORMANT: Wife-Linda Stewart	ADDRESS: Same		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gun Shot Wound of Back — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sodden.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gove rise to immediate couse (a), stoting the underlying couse last. 922.9

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒
21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Yeor: 10/12/69 HOUR A.M. 12 05 P.M.	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.): accidently shot by Brother in law when Hunting
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.): Woods	21f. LOCATION Street or R.F.D. No. / City or Town / County / State: Jewellers Farm - Beallsville - Montgomery Md.

22a. **I certify** that I taak charge of the remains described abave, held an Autapsy ☐, Inspection ☒, Inquiry ☒ and in my apinian death resulted from: Natural causes ☐, Accident ☒ Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G. Bell M.D.
EXAMINER'S NAME (Type)
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ADDRESS(Street, city, town, or county)
22b. DATE SIGNED: Oct. 12, 1969.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 10/16/69	23c. NAME OF CEMETERY OR CREMATORY: Parklawn	23d. LOCATION (City or Town) (County) (State): Rockville Monty. Md	
24. FUNERAL DIRECTOR: W C Hick	ADDRESS: Barnesville Md.	25a. REC'D BY REGISTRAR DATE OCT 20 1969	25b. REGISTRAR'S SIGNATURE: Charles Judge	

VR A15ME (5) 10M REV. 1/68

14 14678

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14676

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
ANNE	nmi	STRATTON	OCT 17 69	1-A 13 M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
FEMALE	WHITE	MAR. 14, 1926	43 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
PA.	USA	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	MONTGOMERY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
SILVER SPRING	HOLY CROSS HOSP.	~~XXXXX~~ Housewife	Own home

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MD	MONTGOMERY (GAITHERSBURG)		YES [X] NO [ ]	18925 DIARY ROAD

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Nicholas		Husak	Mary		Ikacz

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO	- - - -		EUGENE A. STRATTON	SAME

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of colon — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 years
153.8
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from July, 1962, to Oct 17, 1969, that (I) (we) last saw the deceased alive on Oct 16 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE: ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [ ]	22c. DATE SIGNED
[signature]		Oct 17, 1969

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Blaine Eig, M.D.	9801 Georgia Ave Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Cremation	10/18/69	Fort Lincoln Crematory	Bladensburg, Maryland

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
P. Smith Warner E. Pumphrey, Inc.,	8434 Georgia Avenue Silver Spring, Md.	OCT 21 1969	J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M - 7-69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14679 14677

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
JOSEPH	WALKER	STRUDWICK	10 21 69	2:00 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
MALE	NEGRO	Sept 3, 1911	58 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
N.C.	U.S.A.		MONTGOMERY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
BETHESDA	GROSVENOR LANE NURSING HOME		

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
DISTRICT OF COLUMBIA	—	WASHINGTON	YES ☒ NO ☐	227 - 12th ST. N.E.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Amos		STRUDWICK	ORA		Southerlin

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
YES	579-07-53-21	Esther Strudwick	227-12th St. N.E.

MEDICAL CERTIFICATION

1B. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CORONARY HEART DISEASE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 mos.
DUE TO, OR AS A CONSEQUENCE OF
(b) ARTERIOSCLEROTIC PERIPHERAL VASCULAR
DUE TO, OR AS A CONSEQUENCE OF
(c) DISEASE — 2 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 2/8, 19 69, to 10/21, 19 69, that (I) (we) last saw the deceased alive on 10/6 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
R. Lindeman	M.D.	☒	☐	☐	10/21/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	10-25-69	Lincoln Memorial Cemetery	Suitland, Maryland

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
John T. Kline	3015-12th St. N.E.	OCT 27 1969	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and signed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

1

14680

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14678

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use os the buriol-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to buriol, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

1. DECEASED-NAME (Type or print) First: Charlotte	Middle: Elizabeth	Lost: Surber	2a. DATE OF DEATH Month: October Day: 13 Year: 1969
2b. HOUR: 7:15 A M			
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: 2 May 1909	6. AGE (In years last birthday): 60 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN
7a. BIRTHPLACE (State or foreign country): Virginia	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Montgomery Md.
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): The Clinical Center, NIH	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Virginia	13b. COUNTY: Roanoke	13c. CITY OR TOWN: Salem	13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET AND NUMBER: 813 Tennessee Street			
14. FATHER'S NAME First: John	Middle	Lost: Yonce	15. MOTHER'S MAIDEN NAME First: Libbie Middle	Lost: Goodman
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service): --	17. INFORMANT: Not Available	Bethesda, Maryland 20014 The Medical Records, The Clinical Center,

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Gram negative septicemia	4 days
DUE TO, OR AS A CONSEQUENCE OF (b)	Perforated diverticulitis	6 days
DUE TO, OR AS A CONSEQUENCE OF (c)	Idiopathic thrombocytopenic purpura	2 years

Conditions, if ony, which gove rise to immediote couse (a), stoting the underlying cause lost.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [X] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILOING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County Stote	

22a. **I certify** thot ~~XX~~(this hospital) attended the deceased from 15 July, 1969, to 13 Oct., 1969, that ~~I~~ (we) last saw the deceased alive on 13 October 1969, and that in ~~my~~ (aur) apinian death accurred on the date and hour and fram the causes stated above, ~~I~~ (we) (did) (~~did not~~) view the bady after death.

22b. SIGNATURE: Stephen H. Bennett DEGREE: ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [XX] — 22c. DATE SIGNED: 13 October 1969

22d. PHYSICIAN'S NAME (Type): Stephen H. Bennett, M.D. — 22e. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Oct. 15, '69	23c. NAME OF CEMETERY OR CREMATORY: BlueRidge Gardens	23d. LOCATION (City or Town): Roanoke, Va.	(County) (State)
24. FUNERAL DIRECTOR: Murphy Funeral Home	ADDRESS: Rkl. Va.	25a. REC'D BY REGISTRAR: OCT 16 1969	25b. REGISTRAR'S SIGNATURE: Charles Judge	

14681

14679

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First: Vincent Middle: E. Last: Sutliff Sr.	2a. DATE OF DEATH Month Day Year: Oct 29 1969	2b. HOUR: 745 P.M.	
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH: 6-15-1900	6. AGE (In years last birthday): 69 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): New York	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Montgomery Md.
10. CITY OR TOWN OF DEATH: Gaithersburg	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Sunrise Farm, R.F.D. #1	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired Executive - Publications	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Gaithersburg	13d. INSIDE CITY LIMITS? YES [ ] NO [ ] 13e. STREET AND NUMBER: Sunrise Farm, R.F.D. #1
14. FATHER'S NAME First Middle Last: William R. Sutliff	15. MOTHER'S MAIDEN NAME First Middle Last: Katherine C. Carley		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): no (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 107-07-0198	17. INFORMANT Address: V.E. Sutliff Jr., 7315 Wis. Ave., Beth., Md.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): ACUTE VENTRICULAR FIBRILLATION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

410.9

DUE TO, OR AS A CONSEQUENCE OF (b): SECONDARY TO ARTERIOSCLEROTIC HEART DISEASE WITH — SINCE MAR 1969

DUE TO, OR AS A CONSEQUENCE OF (c): SUBENDOCARDIAL MYOCARDIAL INFARCTION

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION: NO	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [✓]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. I certify that (I) (this hospital) attended the deceased from _____, 19__, to PRESENT, that (I) (we) last saw the deceased alive on 10/25 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Reaumur S. Donnally DEGREE	ATTENDING PHYS. [✓] MED. DIRECTOR [ ] STAFF PHYS. [ ]	22c. DATE SIGNED: 10/29/69	
22d. PHYSICIAN'S NAME (Type): Reaumur S. Donnally	22e. ADDRESS: 1827 23RD ST NW WASHDC 20008		
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 11-3-1969	23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cemetery	23d. LOCATION (City or Town) (County) (State): Silver Spring, Mont. Co., Md.
24. FUNERAL DIRECTOR: JOSEPH GAWLER'S SON, INC. ADDRESS: 5130 WISC. AVE., N. W. WASH., D. C. 20016	25a. REC'D BY REGISTRAR DATE: NOV 4 1969	25b. REGISTRAR'S SIGNATURE: J Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M · 1/69

1 14682

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14680

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: JOHN	Middle: HENRY	Last: SUTTON Sr.	2a. DATE OF DEATH Month: 10 Day: 14 Year: 69	2b. HOUR: 4:45 M	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: 11-13-88	6. AGE (In years last birthday): 80 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country): New Jersey	7b. CITIZEN OF WHAT COUNTRY?: U.S.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Montgomery Md.			
10. CITY OR TOWN OF DEATH: Takoma Park	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Wash. San. & Hosp.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Plumber	12b. KIND OF BUSINESS OR INDUSTRY: Retired			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Takoma Park	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 208 Lincoln Ave.		
14. FATHER'S NAME First: Edmond	Middle	Last: Sutton	15. MOTHER'S MAIDEN NAME First: Catherine	Middle	Last: Levens	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes no, or unknown) (If yes give war or dates of service): NO	16b. SOCIAL SECURITY NO.	17. INFORMANT: John H. Sutton, Jr.	Address: ~~Silver Spring,~~ 9405 Worth Ave.,			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Probable Myocardial Infarction — Approximate interval between onset and death: minutes

DUE TO, OR AS A CONSEQUENCE OF

(b): Arteriosclerotic Heart Disease — 4yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Urinary Retention and Cystitis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from 8/29, 1969, to 10/14, 1969, that (I) ~~(we)~~ last saw the deceased alive on 10/7 1969, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ ~~(did)~~ (did not) view the body after death.

22b. SIGNATURE: R T Benack MD DEGREE	ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	22c. DATE SIGNED: 10/14/69	
22d. PHYSICIAN'S NAME (Type): R. T. Benack MD.	22e. ADDRESS: 4115 Blie Dr. Wheaton Md 20906		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 10/ 17/69	23c. NAME OF CEMETERY OR CREMATORY: Parklawn Memorial Park	23d. LOCATION (City or Town) (County) (State): Rockville, Montgomery Md.	
24. FUNERAL DIRECTOR: Tyson Wheeler Funeral Home	ADDRESS: 1331 Rockville Pike Rockville, Maryland	25a. REC'D BY REGISTRAR DATE: OCT 20 1969	25b. REGISTRAR'S SIGNATURE: J. Charles Judge	

VR A13 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14683 — 14681

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year
Henry	W.	Syfrig	Oct. 26. 1969

2b. HOUR: 5-15 A M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
male	white	Nov. 6, 1892	76 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐	9. COUNTY OF DEATH
Conn.	USA		Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Bethesda	Westwood N.H.	Ret. Attorney	Reporting Ser.

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Montgomery	Bethesda	YES ☒ NO ☐	5101 Ridgefield Rd.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Werner		Syfrig	Louise		?

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No or unknown	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT	Address
No	578-46-6211	Mrs. Lucille Bowers	9035 Dunloggin Rd. Ellicott City, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Chronic heart failure. — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 years.

DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis and — years

DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerotic heart disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 412.3

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Multiple sclerosis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (I) (this hospital) attended the deceased from 10-25- 1959, 19___, to 10-25- 1969, that (I) (we) lost saw the deceased alive on 10-25- 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
C P Ryland	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	10-26-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
C P RYLAND. MD	4400-49 St. NW. Wash D C

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Oct. 29, 1969	Fort Lincoln Cemetery	Colmar Manor, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Jos. Gawler's Sons Inc 5130 Wisc, Ave NW Wash, D.C.	NOV 4 1969	J Charles Judge

VR A15 (4) 30M REV. 1-68

1

14684

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14682

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, give the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: CHRIST	Middle: (N.M.I.)	Last: TAMES.	2a. DATE OF DEATH Month: 10 Day: 2 Year: 69	2b. HOUR: 6:40 P M	
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: 12-23-1886	6. AGE (In years last birthday): 82 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): GREECE	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐	9. COUNTY OF DEATH: MONTGOMERY		Md
10. CITY OR TOWN OF DEATH: KENSINGTON	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress): CARROLL HALL N.H.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): RETIRED	12b. KIND OF BUSINESS OR INDUSTRY: N/A		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: D.C.	13b. COUNTY: —	13c. CITY OR TOWN: WASHINGTON	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 4215 YUMA ST. N.W.	
14. FATHER'S NAME First: GEORGE	Middle: —	Last: TAMES	15. MOTHER'S MAIDEN NAME First: UNKNOWN	Middle	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): NO	(If yes give war or dates of service): NO	16b. SOCIAL SECURITY NO.: 579-05-3541A	17. INFORMANT: GEORGE TAMES	Address: SAME AS #13	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY THROMBOSIS — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 HOURS
DUE TO, OR AS A CONSEQUENCE OF
(b): CHRONIC MYOCARDITIS
DUE TO, OR AS A CONSEQUENCE OF
(c): GENERALIZED ARTERIOSCLEROSIS
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
CHRONIC PROSTATITIS

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / Stote	

22a. **I certify** that (I) (~~this hospital~~) attended the deceased from JUNE 4, 1968, to OCT. 2, 1969, that (I) (~~we~~) last saw the deceased alive an OCT. 2 1969, and that in (my) (~~our~~) apinian death accurred an the date and haur and from the causes stated abave, (I) (~~we~~) (did) (~~did not~~) view the bady after death.

22b. SIGNATURE: Henry Ely Lowden MD — DEGREE — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☑ — 22c. DATE SIGNED: 10-2-69

22d. PHYSICIAN'S NAME (Type): HENRY LOWDEN — 22e. ADDRESS: 206 NORWAY DR. CHEVY CHASE, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: 10/4/69	23c. NAME OF CEMETERY OR CREMATORY: CEDAR HILL CEM.	23d. LOCATION (City or Town) (County) (Stote): SUITLAND, P.G. Co. MD.	
24. FUNERAL DIRECTOR: Jos. Gawler's Sons	ADDRESS: WASH., D.C. 5730 Wisc. Ave. NW	25a. REC'D BY REGISTRAR: OCT 10 1969	25b. REGISTRAR'S SIGNATURE: Charles Judge	

VR A15 (4) 45M - 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14685 14683

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print): First Benjamin Middle Franklin Last Taylor
2a. DATE OF DEATH: Month Oct. Day 24 Year 1969
2b. HOUR: 2 3/4 M
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: 8/13/97
6. AGE (In years last birthday): 72 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (State or foreign country): Illinois
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. COUNTY OF DEATH: Montgomery Md.
10. CITY OR TOWN OF DEATH: Bethesda
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Suburban Hospital
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Attorney (Retired)
12b. KIND OF BUSINESS OR INDUSTRY: Vet. Adm.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland
13b. COUNTY: Montgomery
13c. CITY OR TOWN: Kensington
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET AND NUMBER: 9908 East Bexhill Drive
14. FATHER'S NAME First Benjamin Franklin Middle Taylor Last Sr.
15. MOTHER'S MAIDEN NAME First Catherine Middle Ambose Last Baumeister
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: 216-44-9826
17. INFORMANT: Lillian K. Taylor (wife) Address: odd. same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 8 hrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 410.9
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Arteriosclerotic Heart Disease — Uncertain
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this physician) attended the deceased from several years 19___, to 10-24, 1969, that (I) (~~we~~) last saw the deceased alive on 10-24 1969, and that in (my) (~~our~~) opinion death occurred on the date and haur and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: James W. Egan DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] | 22c. DATE SIGNED: 10/24/69

22d. PHYSICIAN'S NAME (Type) JAMES W. EGAN | 22e. ADDRESS 5413 CEDAR LA., BETHESDA, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE 10/29/69 | 23c. NAME OF CEMETERY OR CREMATORY LAGON CATH. CEM. | 23d. LOCATION (City or Town) (County) (State) LAGON, ILLINOIS

24. FUNERAL DIRECTOR ADDRESS: JOS. GAWLER'S SONS, 5130 WIS. AVE., N.W. WASHINGTON, D.C. | 25a. REC'D BY REGISTRAR DATE: OCT 31 1969 | 25b. REGISTRAR'S SIGNATURE: [illegible] Deputy Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

14686

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14684

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 2 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form ME 5. Page 3 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)	First: Delmar	Middle: S.	Last: Taylor, Sr.	2a. DATE KNOWN X OF DEATH ESTIMATED ☐	Month: 10	Day: 29	Year: 1969	2b. HOUR: 6:25 AM PM
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: 6/17/1900	6. AGE (In years last birthday): 69 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD: Month 10	Day 29	Year 1969	2d. HOUR: 6:25 M
7a. BIRTHPLACE (State or foreign country): WASH DC	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: MONTGOMERY Md.						
10. CITY OR TOWN OF DEATH: SILVER SPRING	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HOLY CROSS HOSP	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): D C FIREMAN	12b. KIND OF BUSINESS OR INDUSTRY: FIRE DEPT						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: MONTGOMERY	13c. CITY OR TOWN: SIL SP	13d. INSIDE CITY LIMITS? YES X NO ☐	13e. STREET AND NUMBER: 9219 Woodland Dr.					
14. FATHER'S NAME: First WILLIAM / Middle S / Last TAYLOR	15. MOTHER'S MAIDEN NAME: First EFFIE / Middle / Last ACTON								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): NAVY WW I	16b. SOCIAL SECURITY NO.: 579-46-6213	17. INFORMANT: Wife	ADDRESS: Harriet Taylor-9219 Woodland Dr., Sil. Spg., Md.						

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute Coronary Insufficiency

DUE TO, OR AS A CONSEQUENCE OF (b): Coronary Artery Heart Disease

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 412.3

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO X

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection X, Inquiry X; and in my opinion death resulted from: Natural causes X, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE / EXAMINER'S NAME (Type): Belden R. Reap M.D. — Belden R. Reap, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER X

ADDRESS (Street, city, town, or county): Clinton

22b. DATE SIGNED: Oct. 29, 1969

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Cremation	11/1/69	Ft. Lincoln Crematory	Bladensburg, Maryland

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
C. Glen Carter	8434 Georgia Avenue	DATE NOV 5 1969	Charles Judge
Warner E. Pumphrey, Inc., Silver Spring, Md.			

VR A15ME (5)
10M - 11 69

Items 1,14,15 From the birth certificate 10/24/69 llw

14687

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14685

1. DECEASED NAME (Type or print) First	Middle	Lost	2a. DATE OF DEATH	2b. HOUR
Avis ~~Baby~~ Denise	~~Girl~~	Thompson	Oct. Month 20 Day 69 Year	1:30a M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
Female	Negro	Oct. 20, 1969	1 hour HRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Montgomery	USA	NEVER MARRIED X	Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Olney	Montgomery General Hospital		

13a. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Montg.	Sandy Spring	YES / NO	18471 Brooke Road

14. FATHER'S NAME First	Middle	Lost	15. MOTHER'S MAIDEN NAME First	Middle	Lost
Charles Alvin Bowie			Earline D.	Thompson	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardio-Respiratory failure

DUE TO, OR AS A CONSEQUENCE OF

(b) Immaturity

DUE TO, OR AS A CONSEQUENCE OF

(c) abruptio placenta (50%)

Conditions, if ony, which gave rise to immediate couse (a), stating the underlying couse lost. 770.1

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 8 hours.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES X NO	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	Stote

22a. **I certify** that (I) (this haspitol) ottended the deceosed from _____, 19____, to _____, 19____, thot (I) (we) last saw the deceased alive an _____ 19____, and thot in (my) (our) opinion deoth accurred on the date and haur and from the couses stated above, (I) (we) (did) (did not) view the body ofter deoth.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Chester LeRoy Wagstaff		X	☐	☐	10-20-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Dr. Chester Wagstaff	Sandy Spring Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	10/21/69	Sandy Spring Cemetery	Sandy Spring Montg Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Robert L. Snowden	Rockville, Md	OCT 24 1969	J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

VR A 15 (4) 45M 1/69

1

14688

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14686

1. DECEASED-NAME (Type or print) First: Albert Middle: (None) Lost: TURANO	2a. DATE OF DEATH Month: October Day: 29 Year: 1969	2b. HOUR: 9:00 A M	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: 10-24-1892	6. AGE (In years last birthday) 77 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): Italy	7b. CITIZEN OF WHAT COUNTRY? American	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery County Md.
10. CITY OR TOWN OF DEATH: Takoma Park	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Washington San. and hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Janitor	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Takoma Park	13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET AND NUMBER: 908 Hudson Street
14. FATHER'S NAME First: Melchirorre Middle: Lost: Turano		15. MOTHER'S MAIDEN NAME First: Donenica Middle: Lost: Morrione	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 173-01-0302	17. INFORMANT: Hospital Records Address:	

71
15
1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

185, X

IMMEDIATE CAUSE (a): Gastro intestinal Bleeding - Gastric Ulcer — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Eight Hours

DUE TO, OR AS A CONSEQUENCE OF (b): Carcinoma of Prostate — Unknown

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (I) (this hospital) attended the deceased from 9-22, 1969, to 10-29, 1969, that (I) (~~we~~) last saw the deceased alive on 10-29 1969, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: Stuart L. Nelson	DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 10-30-69
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE: Nov. 3 - 1969	23c. NAME OF CEMETERY OR CREMATORY: Washington Memorial Church	23d. LOCATION (City or Town) (County) (State): York - Valley Forge - Penna
24. FUNERAL DIRECTOR: Arthur Walters	ADDRESS: 254 Carroll St. NC	25a. REC'D BY REGISTRAR DATE: NOV 3 1969	25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

1

FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 4 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) — First: UNKNOWN MALE; Middle; Last

2a. DATE OF DEATH — KNOWN ☐ ESTIMATED ☒ — Month: Oct. Day: Year: 1969

2b. HOUR: M

3. SEX: male

4. RACE: Negro

5. DATE OF BIRTH:

6. AGE (In years last birthday): 40-50 RS. — IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN

2c. DATE PRONOUNCED DEAD — Month: 2 Day: 22 Year: 19 70

2d. HOUR: 3 PM

7a. BIRTHPLACE (State or foreign country):

7b. CITIZEN OF WHAT COUNTRY?

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. COUNTY OF DEATH: Montgomery Md.

10. CITY OR TOWN OF DEATH: Great Falls

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Cabin John- 50 yds E. of Lock 12 C & O Canal

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)

12b. KIND OF BUSINESS OR INDUSTRY

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE

13b. COUNTY

13c. CITY OR TOWN

13d. INSIDE CITY LIMITS? YES ☐ NO ☐

13e. STREET AND NUMBER

14. FATHER'S NAME — First; Middle; Last

15. MOTHER'S MAIDEN NAME — First; Middle; Lost

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16b. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Undetermined (Skeletonized Remains)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b):

DUE TO, OR AS A CONSEQUENCE OF

(c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)

21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☒

ACTUAL SIGNATURE: Russell S Fisher M.D.

EXAMINER'S NAME (Type): Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☐

ADDRESS (Street, city, town, or county)

22b. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE: ~~7/14/70~~ 7/28

23c. NAME OF CEMETERY OR CREMATORY: Office of Chief Medical Examiner

23d. LOCATION (City or Town) (County) (State): 111 Penn Street, Balto., Md.

24. FUNERAL DIRECTOR: R Fisher MD

ADDRESS: 111 Penn Street Balto., Md.

25a. REC'D BY REGISTRAR DATE: JUL 31 1970

25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15ME (5)
10M - 1/69

14689

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14687

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Herbert	Charles	Vallance	October	8	1969	9:35 P.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
Male	White	9 January 1933	36 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
New York	USA		Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Bethesda	The Clinical Center, NIH	Manager	Office Equip.

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Montgomery	Wheaton	YES [X] NO [ ]	4101 Delancy Drive

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
James		Vallance	Lilly Ann		Lawrence

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
Yes	1951-1955	Not available	The Medical Record The Clinical Center, NIH, Bethesda, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Gastrointestinal bleeding — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Days

205.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myelomonocytic Leukemia — Months

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [X] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
			Yes

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that [X] (this hospital) attended the deceased from 19 August, 1969, to 8 Oct., 1969, that [X] (we) last saw the deceased alive on 8 October 1969, and that in [XXX] (our) opinion death occurred on the date and hour and from the causes stated above, [X] (we) (did) [XXXX] view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
R. H. Halterman, MD		[ ]	[ ]	[X]	9 October 1969

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
R. H. Halterman, M. D.	The Clinical Center, National Institutes of Health, Bethesda, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	10/14/69	Gate of Heaven Cemetery	Silver Spring, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Tyson Wheeler Funeral Home	1331 Rock. Pike Rockville, Md.	OCT 14 1969	[illegible] Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M - 1-69

14690

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14688

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
CHRISTIAN	[redacted]	Volz	10	4	69	902 A M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN
MALE	WHITE	6-9-92	77 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
PENNA.	AMERICA		MONTGOMERY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
TAKOMA PARK	WASHINGTON SAN + HOSP	PLUMBER-RETIRED	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	MONT.	Silver Spring	YES ☒ NO ☐	1001 WHITEHALL ST.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
JOHN	MICHAEL	VOLZ	KATHERINE		HAFNER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO	—	203-03-3183	Mrs. Clarissa L. Volz	1001 Whitehall Sil.Spr., Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Myoc. Infarction

DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Cong. failure

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19 67, to Oct 4, 19 69, that (I) (we) last saw the deceased alive on Oct 4 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
R. J. Bufalino		☑	☐	☐	Oct 4 69.

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Russell Bufalino	1429 University Blvd. W. S.S., Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Oct. 6, 1969	Nat'l Mem. Park	Falls Church Virginia

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Francis J. Collins 500 Univ. Blvd. W. Silver Spring, Maryland	OCT 8 1969	J. Charles Jones

VR A15 (4)
45M - 1/69

1

14691

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14689

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

1. DECEASED-NAME (Type or print) First	Middle	Lost	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Elizabeth	D.	Walters	Oct	6	1969	8:30 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN
Female	WHITE	6/3/89	80 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
N. Y.	U. S.A.		Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Silver Spring	Holy Cross Hospital	Housewife	None

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md	Montgomery	Silver Spring	YES ☒ NO ☐	3023 Castleleigh Rd.

14. FATHER'S NAME First	Middle	Lost	15. MOTHER'S MAIDEN NAME First	Middle	Lost
Unknown			Unknown		

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
No		No	Massapequa Funeral Home	99 N. Y. Ave. N. Y.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Myocardial Infarction	5 mo.
DUE TO, OR AS A CONSEQUENCE OF (b)	Arteriosclerotic Cardiovascular Disease	20 yrs
DUE TO, OR AS A CONSEQUENCE OF (c)		

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Cerebral Arteriosclerosis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) ~~(this hospital)~~ attended the deceased from March, 1969, to 10-6, 1969, that (I) ~~(we)~~ last saw the deceased alive on 10-6 1969, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ (did) ~~(did not)~~ view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED
Morton Altschuler					10-6-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Morton Altschuler, M.D.	9205-New Hampshire Ave. Silver Spring Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Oct. 10, 1969	Lutheran Cemetery	Middle Village, New York

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Paul Smith Warner E. Pumphrey Inc.	Ga. Ave., S.S.	OCT 9 1969	Charles Jaeger

VR A15 (4)
45M - 1/69

1

14692

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14690

CERTIFICATE OF DEATH

Item#13a thru e, FilmG418 11/4/69 km

1. DECEASED-NAME (Type or print) First: Joseph Middle: Lost: Walton	2a. DATE OF DEATH Month Oct Day 20 Year 69	2b. HOUR 10 7 AM	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: March 16-1875	6. AGE (In years last birthday) 94 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): England	7b. CITIZEN OF WHAT COUNTRY? U S A	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery Md.
10. CITY OR TOWN OF DEATH: Germantown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Marylander Rest Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired.	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Gaithersburg, Md.	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Gaithersburg	13d. INSIDE CITY LIMITS? YES ☐ NO ☐
13e. STREET AND NUMBER: (Sold before going to E. Diamond Avenue N.H.)			
14. FATHER'S NAME First: William Middle: Lost: Walton	15. MOTHER'S MAIDEN NAME First: Jane Irwin Middle: Lost:		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT: Home Records Address	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Arteriosclerotic cardiovascular disease	10 years
DUE TO, OR AS A CONSEQUENCE OF (b)		
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

412.4

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. I certify that (I) (~~this hospital~~) attended the deceased from 9/19, 1968, to 10/20, 1969, that (I) (~~we~~) last saw the deceased alive on 10/16 1969, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~did~~) (did not) view the body after death.

22b. SIGNATURE: James P. Kerr M.D.	DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 10/20/69	
22d. PHYSICIAN'S NAME (Type): James P. Kerr.	22e. ADDRESS: Damascus. Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation	23b. DATE: Oct 23rd69.	23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln	23d. LOCATION (City or Town) (County) (State): Bladensburg. Md.
24. FUNERAL DIRECTOR: Ernest C. Gartner. Ernest C. Gartner	ADDRESS: Gaithersburg. Md.	25a. REC'D BY REGISTRAR DATE: OCT 23 1969	25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14693 14691

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First	Middle	Last	2o. DATE OF DEATH Month Day Year	2b. HOUR
Milton	A.	Wannall	10 4 1969	10.20 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
Male	Caucasian	5/22/97	72 YRS.		

7o. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
D.C.	U.S.A.		Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12o. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Silver Spg.	Holy Cross Hospital	Retired -	Fireman

13o. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER
Md.	Mont. Gerge	Bethesda		3130 Christine Drive

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Henry	C.	Wannall	Annie	M.	Downey

16o. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
Yes	WWI	577-26-2701	Ethel Wannall (above address) (Wife)

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (o), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (o) Hepatocellular Carcinoma with

DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary metastases.

Conditions, if any, which gave rise to immediate couse (o), stoting the underlying couse last.

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(o)

19o. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20o. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Yeor 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) ~~(this hospital)~~ attended the deceased from January, 19 67, to 10-4, 19 69, that (I) ~~(we)~~ last saw the deceased alive on 10-4 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ ~~(did)~~ (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED
John Geiger, M.D.					10 8 69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
JASON GEIGER, M.D.	8730 Cameron St. Silver Spring, Md. 20910

23o. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	10/8/1969	Cedar Hill Cem.	Suitland, Md.

24. FUNERAL DIRECTOR	ADDRESS	25o. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Nalley's Funeral Home Inc.	Mt. Rainier, Maryland	OCT 8 1969	J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate hos been signed by the attending physicion and completely filled in by the funeral director, page 3 should be detached for use os the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to buriol, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M - 1/69

14694

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14692

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First	Middle	Lost	2o. DATE OF DEATH Month	Day	Year	2b. HOUR
Nellie	Louise	Washington	October	13,	1969	2A. M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
Female	Black	August 3, 1932	37 YRS.		

7o. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Maryland	America		Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12o. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Takoma Park	Washington Sanitarium & Hosp.K;		

13o. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Montgomery	Silver Spring	YES ☒ NO ☐	1010 Quebec Terr

14. FATHER'S NAME First	Middle	Lost	15. MOTHER'S MAIDEN NAME First	Middle	Lost
Albert	Redd		Ethel		Russell

16o. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
no	577-46-2191	Albert Redd- 1312 Saratoga Avenue, NE Patient's chart

MEDICAL CERTIFICATION

1B. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Brain Stem compression	20 days
DUE TO, OR AS A CONSEQUENCE OF (b)	Massive intracerebral haemorrhage	20 hrs
DUE TO, OR AS A CONSEQUENCE OF (c)	Essential hypertension	1+ yrs

Conditions, if any, which gave rise to immediate couse (a), stoting the underlying couse last. 431.0

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19o. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20o. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While ☐ at work Not while ☐ at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (I) ~~(this hospital)~~ attended the deceased from Oct 11, 1969 to Oct 13, 1969, that (I) (we) last saw the deceased alive on Oct 12 1969 and that in (my) ~~(our)~~ opinion death occurred on the date and haur and from the causes stated above, (I) ~~(we)~~ ~~(did)~~ (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
John Thomas Lord	M.D.	☒	☐	☐	Oct 13/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
John Thomas Lord	1015 Spring St. Silver Spring, Md.

23o. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	10-18-69	Harmony Memorial Park	Prince George, Maryland

24. FUNERAL DIRECTOR ADDRESS	25o. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
John T. Rhines Company Funeral Home 3015 12th Street, N. E., Washington, D. C.	OCT 17 1969	J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared with Medical Examiner

VR/A15 (4)
45M - 1/69

14692

14

14695

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14693

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print): First: MARGUERITE; Middle: Helen; Last: WATERS

2a. DATE OF DEATH: Month: 10; Day: 19; Year: 69

2b. HOUR: 1 P.M.

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH: 10-16-10

6. AGE (In years last birthday): 59 YRS.

IF UNDER 1 YEAR: MONTHS; DAYS

IF UNDER 24 HRS: HOURS; MIN

7a. BIRTHPLACE (State or foreign country): Pa.

7b. CITIZEN OF WHAT COUNTRY?: AMER.

8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. COUNTY OF DEATH: Montgomery Md.

10. CITY OR TOWN OF DEATH: Takoma Park Md.

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Wash. San. & Hosp.

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Nurse

12b. KIND OF BUSINESS OR INDUSTRY: Home

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Laurel Md.

13b. COUNTY: Howard

13c. CITY OR TOWN: Laurel Md.

13d. INSIDE CITY LIMITS? YES ☑ NO ☐

13e. STREET AND NUMBER: Rt. 1 Box 264

14. FATHER'S NAME: First: William; Middle: ; Last: Armstrong

15. MOTHER'S MAIDEN NAME: First: Paris; Middle: Maisie; Last: Armstrong

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16b. SOCIAL SECURITY NO.

17. INFORMANT: chart. Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Congestive Heart Failure. 348.0

DUE TO, OR AS A CONSEQUENCE OF

(b): Aspiration Pneumonitis.

DUE TO, OR AS A CONSEQUENCE OF

(c): Amyotrophic Lateral Sclerosis.

Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 7 days 2.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)

21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19

21c. HOW INJURY OCCURRED (Enter noture of injury in Port I or Port 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f. LOCATION Street or R.F.D. No. City or Town County Stote

22a. **I certify** that (I) (this hospital) attended the deceased from 9-26, 19 69, to 10-18, 19 69, that (I) (we) last saw the deceased alive on 10-18 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Burton A. Johnson M.D. DEGREE ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. DATE SIGNED: 10-19-69

22d. PHYSICIAN'S NAME (Type): Burton A. Johnson

22e. ADDRESS: Burtonsville, Maryland.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 10-22-69

23c. NAME OF CEMETERY OR CREMATORY: Savage Cem

23d. LOCATION (City or Town) (County) (State): Savage Md.

24. FUNERAL DIRECTOR: Donaldson Funeral Home, Laurel Md. ADDRESS

25a. REC'D BY REGISTRAR DATE: OCT 28 1969

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4) 45M - 1-69

1

14696

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14694

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: Ralph Middle: Frederick Last: Weadon	2a. DATE OF DEATH Month: 10 Day: 5 Year: 69	2b. HOUR: 6 15 P. M	
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH: 10-19-03	6. AGE (In years last birthday): 65 YRS. IF UNDER 1 YEAR: MONTHS, DAYS IF UNDER 24 HRS.: HOURS, MIN
7a. BIRTHPLACE (State or foreign country): Virginia	7b. CITIZEN OF WHAT COUNTRY?: Amer.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Montgomery Md.
10. CITY OR TOWN OF DEATH: Takoma Park	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Washington Sanitarium	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired	12b. KIND OF BUSINESS OR INDUSTRY: Pressman
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Prince George	13c. CITY OR TOWN: Hyattsville	13d. INSIDE CITY LIMITS? YES [X] NO [ ] 13e. STREET AND NUMBER: 1900 Amherst Road
14. FATHER'S NAME First: Mason Middle: Last: Weadon	15. MOTHER'S MAIDEN NAME First: Mary Middle: F Last: Presgrave		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WW2	16b. SOCIAL SECURITY NO.: 578-05-7725	17. INFORMANT: Washington Sanitarium Address: Records	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Broncho pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 hrs
485X
DUE TO, OR AS A CONSEQUENCE OF (b):
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Metastatic Carcinoma

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County Stote	

22a. I **certify** that (I) (this haspital) attended the deceased from 9-27, 1969, to 10-5, 1969, that (I) (we) last saw the deceased alive on 10/5/69, and that in (my) (our) opinion death occurred on the date ond hour ond from the causes stated above, (I) (we) (did) (did not) view the bady after death.

22b. SIGNATURE: Myron L Lenkin DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] 22c. DATE SIGNED: 10/6/69

22d. PHYSICIAN'S NAME (Type): MYRON L. LENKIN 22e. ADDRESS: 2309 Shorefield Rd. Wheaton Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Oct 8, 1969	23c. NAME OF CEMETERY OR CREMATORY: Arlington National	23d. LOCATION (City or Town) (County) (State): Arlington Arlington Va.
24. FUNERAL DIRECTOR: F. Gasch's Sons	ADDRESS: Hyattsville, Md.	25a. REC'D BY REGISTRAR DATE: OCT 9 1969	25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14697 14695

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): University Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Washington, D.C. — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C.
d. STREET ADDRESS: 1221 M St. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Hazel — Middle: Corine — Last: Webb

4. DATE OF DEATH: Month: 10 — Day: 21 — Year: 19 69

5. SEX: F

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 2/25/1889

9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): goverment employee

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Atlanta, Georgia

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Dennis Smith

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 579-14-5520

17. INFORMANT: Nona Proctor - Sister — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): carcinoma of stomach — INTERVAL BETWEEN ONSET AND DEATH: 10 mo
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from 10/18, 1969, to 10/21, 1969, that (I) ~~(we)~~ last saw the deceased alive on 10/20 1969, and that death occurred at ____ M, from causes and on the date stated above.

22a. SIGNATURE: Mildred E Proctor — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10/24/1969
23c. NAME OF CEMETERY OR CREMATORY: Arlington
23d. LOCATION (City or Town) (County) (State): Arlington, Virginia

24. FUNERAL DIRECTOR: W. Ernest Jarvis Co., Inc. — ADDRESS: 1432 You St. NW
W. ERNEST JARVIS CO

25a. REC'D BY REGISTRAR — DATE: OCT 27 1969

25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

Items 18-22a, Film G 418, 11/4/69, cr

Item #1, Film G419 12/17/69 km

14696

14698

MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 2 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)	First: HERMANN	Middle: Hermann	Last: WEBER	2a. DATE KNOWN X OF DEATH / ESTIMATED ☐	Month: OCT	Day: 7	Year: 1969	2b. HOUR: 12:15	M
3. SEX: MALE	4. RACE: CAUC	5. DATE OF BIRTH: 22 Aug 1882	6. AGE (In years last birthday): 87 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD: Month OCT / Day 7 / Year 1969		2d. HOUR: 12:15	M
7a. BIRTHPLACE (State or foreign country): GERMANY	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED X / NEVER MARRIED ☐ / WIDOWED ☐ / DIVORCED ☐	9. COUNTY OF DEATH: MONTGOMERY Md.						
10. CITY OR TOWN OF DEATH: BETHESDA	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): NAVAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): MACHINIST	12b. KIND OF BUSINESS OR INDUSTRY						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission), STATE: VIRGINIA/N. J.	13b. COUNTY	13c. CITY OR TOWN: Paterson FALLS CHURCH	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER: 708 E. 22nd St. 7343 BARBOUR CT.					
14. FATHER'S NAME First / Middle / Last: Unknown		15. MOTHER'S MAIDEN NAME First / Middle / Last: Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 143-07-0572	17. INFORMANT: R.C. KRUEGER	ADDRESS: FALLS CHURCH, VA. 7343 BARBOUR CT.,						

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Skull Fracture with Acute Subdural Hematoma — 880.X — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

(b): due to Fall

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES X NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY X OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. 10 X P.M. 10/6 1969	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Deceased fell down stairs at home
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK X	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home	21f. LOCATION Street or R.F.D. No. / City or Town: Falls Church / County: Arlington / State: Va.

22a. **I certify** that I took charge of the remains described above, held an Autopsy X, Inspection X, Inquiry X, and in my opinion death resulted from: Natural causes ☐, Accident X, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Belden R. Reap M.D.

EXAMINER'S NAME (Type): BELDEN R. REAP M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER X

ADDRESS (Street, City, Town, or county): Falls Church

22b. DATE SIGNED: Oct. 7, 1969

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	10/10/69	Columbia Gardens Mem.	Arlington, Virginia

24. FUNERAL DIRECTOR / ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Falls Chruch Funeral Home 1102 West Broad St. Falls Church, Va.	OCT 14 1969	Juliarlos Judge

VR A15ME (5) 10M - 1/69

14699

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14697

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
MABEL	C	WEIGAND	10	16	1969	1:15PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
Female	White	Dec 26, 1886	82 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ■ DIVORCED ☐	9. COUNTY OF DEATH
Penn	U.S.A.		Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Kensington	Carroll Hall San.	House Wife	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ■	13e. STREET AND NUMBER
Washington	D.C.			3528 Davenport St NW

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Unk.			Unk.		

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO	NO.		Wm J. McCall	5335 Nebr Ave NW

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: —

412.3

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRAL HEMORRHAGE — 7 DAYS

DUE TO, OR AS A CONSEQUENCE OF (c) GENERALIZED ARTERIOSCLEROSIS —

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

SENILITY

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that ~~(I)~~ (this hospital) attended the deceased from MAY 30, 1969, to Oct. 16, 1969, that ~~(I)~~ (we) last saw the deceased alive on Oct. 16 1969, and that in ~~(my)~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~(I)~~ (we) ~~(did)~~ ~~(did not)~~ view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS. ☐	MED. DIRECTOR ☑	STAFF PHYS. ☐	22c. DATE SIGNED
Henry M. Lowder MD					10/16/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
	5206 Norwood Dr Chevy Chase, Md

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Cremation	10/17/69	Lee's Crematory	Washington D.C.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Lee Funeral Home 300 4th St n.e. D.C.	OCT 20 1969	J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

1

[redacted] 14700

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14698

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Beatrice	Mae	Weir	October	18	1969	7 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN
Female	White	8-3-96	73 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
Massachusetts	USA		Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Takoma Park	Washington Sanitarium + Hospital	None	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER
Maryland	Prince Georges	Hyattsville		2003 Tuckerman Street

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Walter		Eddy			

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
no		Records, Washington Sanitarium + Hospital

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
162.1	IMMEDIATE CAUSE (a) Congestive Heart Failure	4 days
	DUE TO, OR AS A CONSEQUENCE OF (b) Cor Pulmonale	6 months
	DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of the Lung (rt)	10 months

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (I) ~~(this hospital)~~ attended the deceased from 10/8, 1969, to 10/18, 1969, that (I) ~~(we)~~ last saw the deceased alive on 10/18 1969, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) (we) ~~(did)~~ (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
M Irey	11161 N Hampshire ave Silver Springs, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR ~~CREMATORY~~	23d. LOCATION (City or Town) (County) (State)
Burial	Oct 21, 1969	Arlington National	Arlington Arlington Va

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
F. Gasch's Sons Hyattsville, Md.	OCT 23 1969	J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

16

14701

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14700

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use os the buriol-transit permit. Then please remove corbon papers. Pages 1 and 2 should be filed with the State Dept. of Heolth prior to buriol, cremotion, or removal, and in any event, within 72 hours after death.

VR A15 (Rev.) 45M - 1/69

1. DECEASED-NAME (Type or print) First: John	Middle:	Last: Welsh	2a. DATE OF DEATH Month: Oct Day: 12 Year: 1969 — 2b. HOURS: 4A M
3. SEX: male	4. RACE: white	5. DATE OF BIRTH: 10/12/98	6. AGE (In years last birthday): 71 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): Scotland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Montgomery Md.
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Suburban Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): INVENTOR	12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Rockville	13d. INSIDE CITY LIMITS? YES [ ] NO [ ] — 13e. STREET AND NUMBER: 263 Congressional Lane
14. FATHER'S NAME First: Andrew	Middle:	Last: Welsh	15. MOTHER'S MAIDEN NAME First: Anne — Middle: — Last: Houston
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service):	16b. SOCIAL SECURITY NO.: 164-07-7216	17. INFORMANT: Catherine C Welsh	Address: (Same as 13b)

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	UREMIA - CONGESTIVE HEART FAILURE	2-3 DAYS
DUE TO, OR AS A CONSEQUENCE OF (b)	CEREBROVASCULAR ACCIDENT	3 wks
DUE TO, OR AS A CONSEQUENCE OF (c)	GENERALIZED ARTERIOSCLEROSIS	2-3 YRS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 436.9

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from 9-22, 1969, to 10/11, 1969, that (I) (we) last saw the deceased alive on 10/11 1969, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ (did) ~~(did not)~~ view the body after death.

22b. SIGNATURE: Francis C Mayle Jr MD	DEGREE	ATTENDING PHYS. [X]	MED. DIRECTOR [ ]	STAFF PHYS. [ ] — 22c. DATE SIGNED: 10/12/69
22d. PHYSICIAN'S NAME (Type): FRANCIS C MAYLE JR.	22e. ADDRESS: 8218 Wisconsin Ave	Mont	Bethesda	Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 10-15-69	23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven emetery	23d. LOCATION (City or Town): Silver Spring	(County): Md
24. FUNERAL DIRECTOR: Robert A Pumphrey	ADDRESS: 7557 Wisconsin Ave. Bethesda, Md	25a. RECD BY REGISTRAR DATE: OCT 17 1969	25b. REGISTRAR'S SIGNATURE: J Charles Judge	

13

14702

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14699

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: MABEL	Middle: ROSE	Last: WELLS	2a. DATE OF DEATH Month: Oct Day: 19 Year: 1969
2b. HOUR: 12:15 P.M.			
3. SEX: Fe	4. RACE: Cauc.	5. DATE OF BIRTH: Dec. 10, 1880	6. AGE (In years last birthday): 88 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): Ont. CANADA	7b. CITIZEN OF WHAT COUNTRY?: U.S.A	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery Md.
10. CITY OR TOWN OF DEATH: TAKOMA PARK, MD	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Silgo GARDENS Nursing Home 7525 Carroll Ave	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Book Keeper	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD	13b. COUNTY: Montgomery	13c. CITY OR TOWN: TAKOMA PARK	13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 7400 Carroll Ave.			
14. FATHER'S NAME First: James	Middle:	Last: WELLS	15. MOTHER'S MAIDEN NAME First: NOT	Middle: AVAILABLE	Last:
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 414-58-4573B	17. INFORMANT: MRS. JOSEPHINE W. WELLS (Daughter #2) Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Chr Brain Syndrome + chronic failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: yrs

DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerosis

DUE TO, OR AS A CONSEQUENCE OF (c): Cause of Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 440.9

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. I **certify** that (I) (this hospital) attended the deceased from Oct 19 65, 19__ to Oct 19, 19 69, that (I) (we) last saw the deceased alive on ____ 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Chas H Nicholson MD	DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 10/19/69	
22d. PHYSICIAN'S NAME (Type): Chas H Nicholson MD	22e. ADDRESS: 7401 Blair Rd NW DC		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Oct 21. 1969	23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery	23d. LOCATION (City or Town): Colmar Manor	(County): Pr. Geo	(State): Md
24. FUNERAL DIRECTOR: [illegible] Hall	ADDRESS: 357 Carroll St NW Wash DC	25a. ACC'D BY REGISTRAR DATE: OCT 22 1969	25b. REGISTRAR'S SIGNATURE: J Charles Judge		

VR A15 (4) 45M 7/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14703

CERTIFICATE OF DEATH

14701

1. DECEASED-NAME (Type or print): First: Edith; Middle: G.; Last: Whalen
2a. DATE OF DEATH: Month Oct Day 22 Year 69
2b. HOUR: 8P M
3. SEX: Fe
4. RACE: W
5. DATE OF BIRTH: Oct. 27, 1882
6. AGE (In years last birthday): 96 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): D.C.
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. COUNTY OF DEATH: Montgomery Md.
10. CITY OR TOWN OF DEATH: Rockville
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Potomac Valley Nursing Home
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife
12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland
13b. COUNTY: Montgomery
13c. CITY OR TOWN: Bethesda
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 7400 Arrowwood Rd.
14. FATHER'S NAME First / Middle / Last: Unknown
15. MOTHER'S MAIDEN NAME First / Middle / Last: Unknown
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: 214-58-3704
17. INFORMANT: Son Address: Same as Item 13.
Col. Horace K. Whalen

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CVA — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 12 hr.
436.9
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Generalized Arteriosclerosis — 10+yrs
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☒ NO ☐
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. I certify that (I) (~~this hospital~~) attended the deceased from 5/27/, 1969, to 10/22/, 1969, that (I) (~~we~~) last saw the deceased alive on 10/20/ 1969, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: Robert C. Macon M.D. S. N. Jones M.D. — DEGREE — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 10/22/69
22d. PHYSICIAN'S NAME (Type): ROBERT C. MACON S. N. Jones
22e. ADDRESS: 809 Viers Mill Rd. Rockville Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 10-27-69
23c. NAME OF CEMETERY OR CREMATORY: Glenwood Cemetery
23d. LOCATION (City or Town) (County) (State): Washington, D. C.

24. FUNERAL DIRECTOR ADDRESS: ROBERT A. PUMPHREY, Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE: OCT 30 1969
25b. REGISTRAR'S SIGNATURE: Joseph Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

1 8

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

14704

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14702

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ Month	Day	Year	2b. HOUR
George	W.B.	White	10	29	69	1:45 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.	2c. DATE PRONOUNCED DEAD Month	Day	Year	2d. HOUR
Male	White	9/25/09	60 YRS.					10	29	69	1:45 PM

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Pennsylvania	US		Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Silver Spring	Holy Cross Hospital	salesman	Sales

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER
Maryland	Montgomery	SS		902 Benson Tr. SSMd.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Rollo	R	White	Florence		Frantz

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	208-30-6145	wife- Kathryn	902 Benson Tr. SSMd.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Coronary Insufficiency

DUE TO, OR AS A CONSEQUENCE OF

(b) Coronary Artery Heart Disease

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4123

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Belden R. Read M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED Oct. 29, 1969

EXAMINER'S NAME (Type) BELDEN R. READ, M.D. ADDRESS (Street, city, town, or county) Chevy Chase

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	11-2-69	Reichel Cemetery	Saegertown, Pennsylvania

24. FUNERAL DIRECTOR	ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Francis J. Collins	500 University Blvd. W., Silver Spring, Md.	OCT 31 1969	Deputy Judge

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M - 1/69

1

FOR STATE HEALTH DEPT.

14705

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14703

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)	First: JOHN	Middle: PATRICK	Last: WHITE	2a. DATE KNOWN OF DEATH ☒ / ESTIMATED ☐	Month: 10 Doy: 2 Year: 69	2b. HOUR: 7 42 A.M.
3. SEX: M	4. RACE: Cauc	5. DATE OF BIRTH: 12-18-1915	6. AGE (In years last birthday): 53 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS: HOURS / MIN.	2c. DATE PRONOUNCED DEAD Month: 10 Doy: 2 Year 19: 69		2d. HOUR: 7 42 A.M.
7a. BIRTHPLACE (State or foreign country): Mass.	7b. CITIZEN OF WHAT COUNTRY?: U. S.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery Md.			
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Suburban	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Deputy Asst. Sec. of State-Govt	12b. KIND OF BUSINESS OR INDUSTRY:			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md	13b. COUNTY: Montgom	13c. CITY OR TOWN: Rockville	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 10401 Grosvenor Pl.		
14. FATHER'S NAME First: Patrick	Middle	Last: White	15. MOTHER'S MAIDEN NAME First: Mary	Middle	Last: Harvey	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WW II	16b. SOCIAL SECURITY NO.: 011-24-7494	17. INFORMANT: Wife	ADDRESS: Same as Item 13			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute Coronary Insufficiency

DUE TO, OR AS A CONSEQUENCE OF (b): Coronary Artery Heart Disease

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4123

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒
21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Doy, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, form, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Belden R. Reap M.D.

EXAMINER'S NAME (Type): BELDEN R. REAP

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, city, town, or county): [illegible]

22b. DATE SIGNED: Oct. 2, 1969

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 10-4-69	23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cem.	23d. LOCATION (City or Town) (County) (State): Silver Spring, Maryland	
24. FUNERAL DIRECTOR: ROBERT A. PUMPHREY, Bethesda, Maryland	ADDRESS	25a. REC'D BY REGISTRAR DATE: OCT 6 1969	25b. REGISTRAR'S SIGNATURE: J. Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funerol director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

1

14706

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14704

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH	2b. HOUR
John	LEO	Wilkinson	10 Month 26 Day 69 Year	M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Male	White	1/26/87	82 YRS.	8	

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
~~Maryland~~ D.C.	U. S. A.	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Silver Spring	Holy Cross	Standard Oil Co.	Fuel Co.

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Montgomery	Silver Spring	YES [X] NO [ ]	8715 First Ave.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
THEODORE	WILKINSON		ROSE	HIGGS	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO	No	216052336A	John Ingalls (grand son in law	1110 FIDLER LA SILVER SPRING MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	150.X	
DUE TO, OR AS A CONSEQUENCE OF (b)	Metastatic carcinoma esophagus	3 mos.
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Duodenal ulcer

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from August, 1962, to October, 1969, that (I) (we) last saw the deceased alive on October 25 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Fidel J. Quintana	ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	10-26-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
FIDEL J. QUINTANA	8750 GEORGIA AVE, S. SPRING, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	10-29-1969	Rock Creek Cem	Washington, D.C.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
W.W. Chambers Co.	Riverdale, Maryland	OCT 29 1969	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

Released by Medical Examiner Dr. Leap

VR A15 (4)
45M - 1/69

1

FOR STATE HEALTH DEPT.

Item#23b Film#0417 10/25/69 vbw

14707

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14705

1. DECEASED-NAME (Type or Print)	First: Annette	Middle: Lorraine	Last: Williams	2a. DATE OF DEATH: KNOWN ☒ ESTIMATED ☐	Month: 10	Day: 12	Year: 1969	2b. HOUR: 3:45 PM			
3. SEX: F	4. RACE: W	5. DATE OF BIRTH: 4-22-46	6. AGE (In years last birthday): 23 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD: Month: Oct	Day: 12	Year: 1969	2d. HOUR: 3:45 PM		
7a. BIRTHPLACE (State or foreign country): California	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery Md.								
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Suburban Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Teacher	12b. KIND OF BUSINESS OR INDUSTRY: Linggie Hgts Jr. High School								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Frederick	13c. CITY OR TOWN: Frederick	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 1337 Taney Ave. Apt 302							
14. FATHER'S NAME: First Hamilton	Middle A.	Last Smith	15. MOTHER'S MAIDEN NAME: First	Middle McKim	Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 571-68-2443	17. INFORMANT: Charles J. Williams, Jr.	ADDRESS: Husband 611 Sligo							

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Maceration & Laceration of Brain - 812.1	-3 hr.
DUE TO, OR AS A CONSEQUENCE OF (b)	Compound Fracture of Skull	3 hr.
DUE TO, OR AS A CONSEQUENCE OF (c)	Trauma from Auto Accident	3 hr.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 12:40 P.M. 10/12 1969	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Passenger in car involved in collision w Truck	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Highway	21f. LOCATION Street or R.F.D. No. 705 North Lane	City or Town Gaithersburg	County Montgomery	State Md

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G. Ball M.D.

EXAMINER'S NAME (Type): John G. Ball M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, city, town, or county): Montgomery County

22b. DATE SIGNED: Oct 12, 1969

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Oct. 16, 1969	23c. NAME OF CEMETERY OR CREMATORY: Wasco Cemetery	23d. LOCATION (City or Town) (County) (State): Wasco, Kern County, Calif.	
24. FUNERAL DIRECTOR: Robert E. Dailey & Son	ADDRESS: Frederick, Maryland	25a. REC'D BY REGISTRAR DATE: OCT 15 1969	25b. REGISTRAR'S SIGNATURE: J. Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

1 X

14708

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14706

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
LIDA	WARE	WILLIAMS	oct	10	1969	11:30 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
F	CAUC.	4-12-75	94 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Hancock Wisc.	U.S.A.	WIDOWED [X]	Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Silver Spring	Carriage Hill.	Housewife	—

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
D.C.	D.C.	Wash. D.C.	YES [X] NO [ ]	~~4807~~ 917 McKinley St. NW D.C.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Walter		Ware	Louisa	Elizabeth	French

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
No	579-60-2813	Medical Record. Carriage Hill N.H. S.S. Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiac Arrest.	
DUE TO, OR AS A CONSEQUENCE OF (b)	Heart Failure	
DUE TO, OR AS A CONSEQUENCE OF (c)	Arteriosclerotic H. D.	

412.3

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Senility

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		NO [X]	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 9-18, 19 69, to 10 oct, 19 69, that (I) (we) last saw the deceased alive on oct 10 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
William D. Troyer Jr.		☐	☐	[X]	11 oct 1969

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
	1820 Metzerott Rd Adelphi Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	10-13-1969	Cedar Hill Cemetery	Suitland, P.G. Co., Maryland

24. FUNERAL DIRECTOR	ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
JOSEPH GAWLER'S SON, INC.	5130 WISC. AVE., N. W. WASH., D. C. 20016	OCT 15 1969	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

14708

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14709 (14707)

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death unless any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, ar removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)	First: Margaret	Middle: Elaine	Last: Williams	2a. DATE KNOWN OF DEATH ☒ / ESTIMATED ☐	Month: 10	Day: 16	Year: 1969	2b. HOUR: A.M. 1:20			
3. SEX: F	4. RACE: Negro	5. DATE OF BIRTH: 5/23/1921	6. AGE (In years last birthday): 48 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD: Month 10 Day 16 Year 19 69	2d. HOUR: 1:20 A.M.				
7a. BIRTHPLACE (State or foreign country): N. Carolina	7b. CITIZEN OF WHAT COUNTRY?: U.S.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery Md.								
10. CITY OR TOWN OF DEATH: Wheaton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): University Nursing Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Domestic	12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: D.C.	13b. COUNTY: D.C. ✓	13c. CITY OR TOWN: Washington	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 1311 Columbia Road N.W.							
14. FATHER'S NAME First: NATHANIEL ~~Unknown~~	Middle: ~~unknown~~	Last: Burnett	15. MOTHER'S MAIDEN NAME First: Rose	Middle: unknown	Last: unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: unknown	17. INFORMANT: LACY WILLIAMS HUSBAND	ADDRESS							

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Generalized Carcinomatosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
170.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) due to Metastatic squamous
DUE TO, OR AS A CONSEQUENCE OF (c) cell Carcinoma, left mandible

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Belden R. Reap M.D.
EXAMINER'S NAME (Type): BELDEN R. REAP, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ADDRESS (Street, city, town or county): [illegible]
22b. **DATE SIGNED**: Oct. 16, 1969

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 10/22/69	23c. NAME OF CEMETERY OR CREMATORY: HARMONY PARK	23d. LOCATION (City or Town): LANDOVER (County): MD. (State):
24. FUNERAL DIRECTOR: ROLLINS, INC.	ADDRESS: 4339 HUNT PL. NE. DC.	25a. REC'D BY REGISTRAR DATE: OCT 23 1969	25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 ME (5)
10M REV 1-68

17

14710

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14708

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First	Middle	Lost	2a. DATE OF DEATH Month Day Year	2b. HOUR
ROBERT	JAY	WILLIAMS	October 25 1969	1015 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In yeors last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
MALE	CAUCASIAN	12 NOV 1913	55 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
WASHINGTON	USA		MONTGOMERY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
BETHESDA	NAVAL HOSPITAL	RETIRED MILITARY	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
VIRGINIA		ANNANDALE	YES XX NO [ ]	3914 FOREST GROVE DR.

14. FATHER'S NAME First	Middle	Lost	15. MOTHER'S MAIDEN NAME First	Middle	Lost
JAY	CARL	WILLIAMS	ROSE		BUTLER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
YES	1936-1960	534-38-7066	FRANCES WILLIAMS, 3914 FOREST GROVE DR	ANNANDALE, VA.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE LIVER FAILURE
571.8
DUE TO, OR AS A CONSEQUENCE OF
(b) NUTRITIONAL CIRRHOSIS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES XX NO [ ]	YES

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that XX (this hospital) attended the deceased from 5 OCT, 1969, to 25 OCT, 1969, that XX (we) last saw the deceased alive on 25 OCT 1969, and that in ~~my~~ XX (our) opinion death occurred on the date and hour and from the causes stated above, XX (we) (did) ~~did not~~ view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
[signature]		[ ]	[ ]	[ ]	25 OCT 69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
H. B. McCORMACK, M.D.	NAVAL HOSPITAL, BETHESDA, MARYLAND

23a. BURIAL, ~~CREMATION~~, ~~REMOVAL~~ (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
	10/28/69	ARLINGTON NATIONAL	ARLINGTON		VA.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
FALLS CHURCH FUNERAL HOME 1102 W. BROAD ST. FALLS CHURCH, VA.	OCT 29 1969	J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

1

FOR STATE HEALTH DEPT

14711

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14709

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)	First: Thomas	Middle: H	Last: Williams	2a. DATE KNOWN OF DEATH ☒ / ESTIMATED ☐	Month: 10	Day: 29	Year: 1969	2b. HOUR: 2:00 P.M.
3. SEX: M.	4. RACE: W.	5. DATE OF BIRTH: Sept. 5, 1885	6. AGE (In years last birthday): 84 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD: Month: Oct	Day: 29	Year: 1969	2d. HOUR: 2:15 P.M.
7a. BIRTHPLACE (State or foreign country): S. Carolina	7b. CITIZEN OF WHAT COUNTRY?: U.S.A	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery Md.						
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Dorset + River Rd	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): retired executive	12b. KIND OF BUSINESS OR INDUSTRY: Petroleums						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Ohio	13b. COUNTY: —	13c. CITY OR TOWN: Shaker Hgts	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 3175 Warrington Road					
14. FATHER'S NAME First / Middle / Last: Thomas H. J. Williams		15. MOTHER'S MAIDEN NAME First / Middle / Last: Julia E. Middleton							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no	(If yes give war or dates of service): - - - - - -	16b. SOCIAL SECURITY NO.: 272-10-4559	17. INFORMANT: Elizabeth Davies, Bethesda, Maryland 20034	ADDRESS: 6624 Rannach Road					

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple Injuries Severe. — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden
812.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Trauma from Auto Accident
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 2:00 10-29 1969	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.): Street	21f. LOCATION Street or R.F.D. No.: Dorset + River Rd	City or Town: Bethesda	County: Montgomery	State: Md

Driver car into path of another Car.

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G. Ball M.D.
EXAMINER'S NAME (Type): JOHN G. BALL, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ADDRESS(Street, city, town, or county): MONTG. Co., MD.
22b. DATE SIGNED: oct 30, 1969

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Cremation	10/31/1969	Cedar Hill Crematory	Suitland, Prince Georges, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Jos. Gawler's Sons, Inc	5130 Wisconsin Ave NW Washington DC 20016	NOV 4 1969	J. Charles Judge

VR A15ME (5) 10M REV. 1/68

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death unless any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, crematian, ar removal, and in any event within 72 haurs after death.

14712

14710

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)	First: Zobeide	Middle: L.	Last: Wilson	2a. DATE KNOWN OF DEATH / ESTIMATED	Month: 10	Day: 9	Year: 1969	2b. HOUR: 100 PM
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: 3/17/95	6. AGE (In years last birthday): 74 YRS.	IF UNDER 1 YEAR: MONTHS 6	IF UNDER 24 HRS.: DAYS 22	HOURS	MIN.	2c. DATE PRONOUNCED DEAD: Month 10 Day 9 Year 1969	2d. HOUR: 1P M

7a. BIRTHPLACE (State or foreign country): Maine	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Montgomery Md.	
10. CITY OR TOWN OF DEATH: Silver Spring	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): 14701 Homecrest Road	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institutian: Residence before admission) STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Silver Spg.	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER: 14701 Homecrest Road

14. FATHER'S NAME: First George W.	Middle	Lost Larrabee	15. MOTHER'S MAIDEN NAME: First Carman R. Middle	Lost Young
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): ----------	16b. SOCIAL SECURITY NO.: 217-36-7075	17. INFORMANT: Mrs. Hanson Watkins-Daughter	ADDRESS	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute Coronary Insufficiency — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic Heart Disease

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [ ] NO [X]
21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held on Autopsy [ ], Inspection [X] Inquiry [X], and in my opinian death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Belden R. Reap M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

EXAMINER'S NAME (Type): Belden R. Reap

ADDRESS (Street, city, town, or county): 11502 Grandview Ave. Wheaton, Maryland

22b. DATE SIGNED: Oct. 9, 1969

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 10/13/69	23c. NAME OF CEMETERY OR CREMATORY: Parklawn Memorial Park	23d. LOCATION (City or Town): Rockville,	(County): Montg.	(State): Maryland

24. FUNERAL DIRECTOR: Tyson Wheeler Funeral Home	ADDRESS: 1331 Rock. Pike Rockville, Md.	25a. REC'D BY REGISTRAR DATE: OCT 14 1969	25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5)
10M REV. 1/68

14713

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14711

1. DECEASED-NAME (Type or print) First: Howard Middle: James Lost: Wood	2a. DATE OF DEATH Month: 10 Day: 31 Year: 1969	2b. HOUR: 9:30AM	
3. SEX: Male	4. RACE: Negro	5. DATE OF BIRTH: 9/13/1895	6. AGE (In years last birthday): 74 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): Virginia	7b. CITIZEN OF WHAT COUNTRY?: U.S.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery Md.
10. CITY OR TOWN OF DEATH: Wheaton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): University Nursing Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Railroad Employee	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Wash. D.C.	13b. COUNTY: D.C.	13c. CITY OR TOWN: Wash.	13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET AND NUMBER: 233 Q St. N.W.
14. FATHER'S NAME First: Thomas Middle: unknown Lost: Wood	15. MOTHER'S MAIDEN NAME First: Georgiana Middle: unknown Lost: Mansfield		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): no (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: unknown	17. INFORMANT: Iona Matthews Address: 233 Q St N.W.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Carcinoma of Stomach with metastases — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 mos

151.9

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (I) (this hospital) attended the deceased from 10/30, 1969, to 10/31, 1969, that (I) (we) last saw the deceased alive on 10/30 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Myron L Lenker	DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 10/31/69	
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE: 11-3-69	23c. NAME OF CEMETERY OR CREMATORY: Harmony	23d. LOCATION (City or Town) (County) (State): Sandoxen, Md
24. FUNERAL DIRECTOR: Fragier F.H.	ADDRESS: 389 R.I. Ave N.W.	25a. REC'D BY REGISTRAR DATE: NOV 6 1969	25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M · 1/69

15

14714

14712

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or print) First: Jean	Middle: B	Last: Wright	2a. DATE OF DEATH Month: October Day: 19 Year: 1969
2b. HOUR: 4:30 AM			
3. SEX: Female	4. RACE: Caw.	5. DATE OF BIRTH: 4/26/95	6. AGE (In years last birthday): 74 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN
7a. BIRTHPLACE (State or foreign country): MAryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery Md.
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Grovsnor Nursing Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY: School Teacher
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MAryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Bethesda	13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 4704 Locust Hill Ct.			
14. FATHER'S NAME First: EMMANUEL	Middle: P.	Last: BOTELER	15. MOTHER'S MAIDEN NAME First: EMMA Middle: SABINA Last: ROHNER
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 220-44-6652	17. INFORMANT: JOANNE WIDMAYER	Address: 4704 LOCUST HILL Ct.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiac Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1hr

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 412.3

DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic heart disease — 10yrs

DUE TO, OR AS A CONSEQUENCE OF (c): Diabetes mellitus — 2 YRS.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Bronchial asthma

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (I) (this hospital) attended the deceased from 10/16, 19 69, to 10/19, 19 69, that (I) (we) last saw the deceased alive on 10/18/69 19___, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Ronald Barr	DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 10-19-69
22d. PHYSICIAN'S NAME (Type): RONALD W. BARR, M.D.	22e. ADDRESS: 10401 OLD GEORGETOWN Rd BETHESDA, Md	

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 10-22-69	23c. NAME OF CEMETERY OR CREMATORY: Arlington National Cem.	23d. LOCATION (City or Town): Arlington	(County) (State): Va.
24. FUNERAL DIRECTOR: Robert A. Pumphrey	ADDRESS: 7557 Wisc. Ave. Bethesda, Md.	25a. REC'D BY REGISTRAR DATE: OCT 23 1969	25b. REGISTRAR'S SIGNATURE: Charles Judge	

VR A15 (4)
45M - 1/69

1

FOR STATE HEALTH DEPT.

Items 18, 22a
Film G 419, 12/5/69, cr

14715

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14715

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) First	Middle	Last
JOHN	MILTON	YOUNG

2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ Month	Day	Year	2b. HOUR
10/29		1969	1:05 am

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS. HOURS	IF UNDER 24 HRS. MIN.
Male	Cau.	10/23/12	57 YRS.				

2c. DATE PRONOUNCED DEAD Month	Day	Year	2d. HOUR
10	29	19 69	1:05 am

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
XX/DC	U.S.A.		Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Silver Spring	Holy Cross Hospital	Electrician	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MD	Montgomery	Silver Sp.	YES ☒ NO ☐	722 Sligo Ave.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
John M.		Young	Janie		Bailey

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	1942-1946	579-10-9463	Chart	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Coronary Thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

410.9

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Heart Disease

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Belden R. Reap M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type) BELDEN R. REAP, M.D. ADDRESS (Street, city, town, or county) Silver Spring

22b. DATE SIGNED Oct. 29, 1969

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	10-31-69	Cedar Hill Cemetery	Suitland, Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Francis J. Collins 500 University Blvd.W., Silver Spring, Md.	OCT 31 1969	J. Charles Judge

VR A15ME (5) 10M - 1-69

1

FOR STATE HEALTH DEPT.

14716

14714

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 2 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form ME 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or Print)	First	Middle	Last	2a. DATE KNOWN OF DEATH / ESTIMATED	Month	Day	Year	2b. HOUR
	Charles	Edward	Zimmerli Jr.	☒ / ☐	10-	24	-69	7:00 A M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS	DAYS	IF UNDER 24 HRS.: HOURS	MIN.	2c. DATE PRONOUNCED DEAD: Month	Day	Year	2d. HOUR
Male	W	2-7-07	62 YRS.					10-	24	69	7:00 A M

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Wash., D.C.	U.S.A.		Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Takoma Park	Washington San & Hosp	Elevator Inspector	-

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Pri Geo	Hyattsville	YES ☐ NO ☐	821 Chillum Rd.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Charles	Edward	Zimmerli	Emily	Pauline F.	Schleunig

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	-	578-07-8147	Pauline F. Zimmerli	- above address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Coronary Insufficiency (if any)

DUE TO, OR AS A CONSEQUENCE OF

(b) Coronary Artery Heart Disease.

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 412.3

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Belden R. Reap M.D.

EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, city, town, or county) Rockville

22b. DATE SIGNED Oct. 24, 1969

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	10/28/69	Glenwood Cemetery	Wash., D.C.

24. FUNERAL DIRECTOR	ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Nalley's Funeral Home Inc.	Mt. Rainier, Maryland	OCT 30 1969	Beverly Judge

VR A15ME (5)
10M - 1/69